

Care service inspection report

Hillend View

Care Home Service Adults

14 Airdrie Road
Caldercruix
Airdrie
ML6 8PA

Inspected by: Alison Iles

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Type of inspection: Unannounced

Inspection completed on: 26 October 2012



Contents

	Page No
Summary	3
1 About the service we inspected	5
2 How we inspected this service	6
3 The inspection	13
4 Other information	33
5 Summary of grades	34
6 Inspection and grading history	34

Service provided by:

Hillend View Limited

Service provider number:

SP2011011741

Care service number:

CS2011304898

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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	1	Unsatisfactory
Quality of Environment	1	Unsatisfactory
Quality of Staffing	2	Weak
Quality of Management and Leadership	2	Weak

What the service does well

This service has been operating since the 29 February 2012.

Appropriate referrals were made to relevant healthcare professionals as needed. We observed some positive relationships between residents and staff.

What the service could do better

The service needs to be more proactive in addressing and seeking solutions to the high volume of violent and aggressive incidents that occur within the home. This is in order to ensure that the environment is safe and to protect service users as well as staff.

The service needs to ensure that when staff are recruited that they only commence work once all the necessary checks have been carried out. This includes relevant police checks under the Protecting Vulnerable Groups Scheme (PVG Scheme).

A detailed training programme needs to be developed and implemented within the home to ensure that all staff have the necessary skills and experience to meet the care and support needs of the service users. Where training is identified, including refresher training, this should be delivered to all staff within a set timeframe. We identified significant issues in relating to the accommodation particularly in relation to management of infection prevention and control which need to be

addressed urgently by the provider. This is to help ensure that the environment is safe and service users protected.

What the service has done since the last inspection

The service has failed to address the requirements and recommendations made at the last inspection.

A new manager, who took up post in September 2012 was in the process of getting to know the service and attempting to prioritise where actions were needed.

A new induction programme has been introduced and staff who have recently been recruited commented positively on the content of this and its relevance to their roles and responsibilities.

Conclusion

The service had been operated by a new provider since February 2012.

As stated above the manager had only been in post since September 2012 and was in the process of pulling together an action plan to take forward issues identified.

The provider had not been proactive in ensuring that where requirements, recommendations and areas highlighted for improvement were made at the last inspection that these had been addressed. Failure to do so had had a clear impact on the service being delivered to those living in the home.

This has resulted in the grades awarded to the service being reduced to weak and unsatisfactory across the five Quality Statements looked at.

Who did this inspection

Alison Iles

Liz McPake

Alan Paterson

David Marshall

Audrey Mackenzie

1 About the service we inspected

This service was registered by us on the 29 February 2012. Hillend View is a privately owned care home set in extensive grounds close to the village of Caldercruix in North Lanarkshire.

The home operates from two buildings and provides care and support for up to 80 adults with mental health issues. There were 79 service users at the time of the inspection.

The service has a statement of its aims and objectives which include:

- * To treat all service users, their relatives and carers courteously and with respect;
- * To be responsive to the needs of service users by providing a holistic person centred approach to care;
- * To ensure that there is sufficient care staff, appropriately trained and experienced to meet the needs of service users;
- * To provide and maintain a safe environment at all times.

A new manager had been appointed and took up post in September 2012.

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

Quality of Care and Support - Grade 1 - Unsatisfactory

Quality of Environment - Grade 1 - Unsatisfactory

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 0845 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 compiled this report following an unannounced inspection. The inspection was carried out by Inspectors Alison Iles, Liz McPake and Alan Paterson. David Marshall Pharmacy Advisor and Audrey Mackenzie Infection Control Advisor also took part.

The unannounced inspection took place on the 22 October 2012 between 7.50am and 6pm and 23 October 2012 between 8am and 12noon and 7.45pm and 10.45pm. Feedback was provided to the manager and depute manager of the service on the 26 October 2012.

In this inspection we only consider Quality Statements 1.3, 2.2, 3.2, 3.3 and 4.2. We gathered evidence form various sources, including the relevant sections of policies, procedures, records and other documents including:

- * observing how staff work
- * personal plans of people who use the service
- * staff training records
- * staff recruitment records
- * health and safety records
- * Incident and Accident Records for Service Users.
- * Incident Accident Records for Staff.
- * Medication Records.
- * Staffing Roster.
- * examining equipment and the environment port

Interviews carried out with

- * Service Users
- * Depute Manager
- * Trained Nurses
- * Care Assistants

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

The provider must develop the assessment procedures for each service user to allow the development of full and relevant personal plans. These must be regularly updated to ensure that they continue to clearly reflect the care and support needs of the individual. This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 5 Personal plans. Timescale for implementation: 2 months from receipt of this report.

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The provider must ensure that all service users personal plans are fully reviewed at least once in every 6 months. This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 5(b)(iii) - Review of personal plans. Timescale for implementation: 1 month from receipt of this report.

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The provider must ensure that there are robust systems in place to record and audit incidents occurring in the home. They must be able to evidence what actions are being taken to reduce the likelihood of incidents reoccurring. This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 4(1)(a) - a requirement that the Provider must make proper provision for the health, welfare and safety of service users. Timescale for implementation: 1 month from receipt of this report.

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The service provider must ensure the health and welfare of residents. To do this they must ensure that medication is administered as instructed by the prescriber. In order to achieve this, the service will need to ensure that medication is available at the time of administration. This is in order to comply with: SSI 2011/210 Regulation 4 (1)(a) - a requirement to make proper provision for the health and welfare of people, and SSI 2011/210 Regulation 4 (1)(c) - a requirement to ensure that no-one is subject to restraint unless it is the only practicable means of securing the welfare of that or any other resident Timescale for implementation: 1 week from receipt of this report.

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The service provider must ensure a medication recording system that is safe, up to date and accurate. To do this they must ensure all handwritten entries on MAR charts are signed and dated the person making the change, and referenced to indicate where the handwritten information was obtained, or the authority for any change of dose. SSI 2011/210 Regulation 4 (1)(a) - a requirement to make proper provision for the health and welfare of people. Timescale for implementation: 1 week from receipt of this report.

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The provider must ensure that a training plan is in place that provides staff with the necessary skills to address service user's care and support needs. This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 15(b)(i) - a requirement that the Provider ensures that persons employed in the provision of the care service receive training appropriate to the work they are to perform. Timescale for implementation: 3 months from receipt of this report

What the service did to meet the requirement

See Quality Statement 1.3 for detail

The requirement is: Not Met

The requirement

The provider must review their financial procedures to ensure that they take action to address all the points raised above in relation to the management of finances. This is in order to comply with SSI/2011/210 Regulation 4 (1) (a), Welfare of service users - providers shall make provision for the health and welfare of service users and Regulation 5 Personal plans. Timescales: Within 2 weeks of receipt of this report

What the service did to meet the requirement

This requirement was not considered as part of this inspection.

The requirement is: Not Met

The requirement

The provider must be able to demonstrate that when staff are recruited that all necessary checks have been carried out and results obtained prior to them commencing employment. Or in exceptional circumstances that appropriate measures put in place to supervise staff until the relevant police checks have been carried out. This must include any staff being reemployed by the service. This is in order to comply with SSI 2011/210 Regulation 9 - Fitness of employees Timescale for implementation: 1 week from receipt of this report.

What the service did to meet the requirement

See Quality Statement 3.2 for detail

The requirement is: Not Met

The requirement

The provider must ensure that staff treat and value service users as individuals. All staff must receive appropriate values based training. The service must monitor and address staff practice in relation to this area. This is in order to comply with SSI 2011/210 Regulation 15(b) (I) - a requirement that the Provider shall ensure that persons employed in the provision of the care service receive training appropriate to the work they are to perform. Timescale for implementation: 2 months from publication date of this report

What the service did to meet the requirement

See Quality Statement 3.2 for detail

The requirement is: Not Met

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: not required

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.

A self assessment was not requested as part of this inspection.

Taking the views of people using the care service into account

We spoke with a number of service users during the inspection. For many there days were spent in the smoke rooms only coming out for meal times. Others spend a significant part of the day in their own rooms.

People indicated that there was little going on in the home for them to take part in. Generally people spoke positively about staff although we could evidence that where staff tried to stick to boundaries that they became a target for criticism from service users.

In line with past findings due to service users memory impairments a number were unable to say why they were living in Hillend View but again people indicated that they would like to be back living in their own communities.

A couple of service users spoken with were able to comment positively on the

supports they received from staff and that on occasions staff went that extra mile to support them through difficult times.

Service users were able to comment on the violent incidents that occurred particularly with in the smoke room and of those service users who were likely to instigate these.

Again most people were unaware of their personal care plans. For some people this may be related to memory impairment as a result of their health conditions.

Taking carers' views into account

No relatives or representatives were spoken with during this inspection.

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: 1 - Unsatisfactory

Statement 3

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

Service strengths

Taking in to account the evidence presented at this inspection in relation to this Quality Statement we have re-graded this service from weak to unsatisfactory.

Our focus at this inspection was to review progress made on the requirements made at the last inspection and subsequent regulatory activity in relation to this Quality Statement. We also examined the high number of incidents that had occurred between service users that had resulted in notifications being made to us. We also considered those made to North Lanarkshire Council's Social Work department in terms of Adult Support and Protection issues and to the police as a result of assaults or service users absconding.

All service users were registered with the one General Practice. This was in line with contractual agreements reached with NHS Lanarkshire. This meant that the service received at least two visits a week from a GP as well as additional visits as necessary. The NHS was currently negotiating a new GP contract with a different practice and this was due to take effect from 1 December 2012.

Where needed, appropriate referrals for advice and guidance continued to be made to other health professionals such as: Community Psychiatric Nurses, Dentists and Dieticians. Staff supported service users to attend health care appointments outwith the service when needed. Staff spoken with commented positively on the inputs service users received from health professionals.

The service also benefited by employing its own full time Occupational Therapist (OT) and having a contract with two Psychiatrists who provide a regular input to service users where needed. There was some evidence of the OT starting to undertake fuller

assessments on service users and where possible trying to engage with people to work on their life skills and improve areas of independence.

Relationships between staff and service users were observed to be good. Staff showed respect to service users when engaging with them.

A Care Inspectorate Pharmacy Adviser carried out part of the inspection in relation to medication. This identified the following;

The medication records in the care home were pre-printed medication administration recording [MAR] charts supplied by the community pharmacist. Repeat medication was supplied to the care home with the MAR on a 28 day cycle. We sampled MAR charts from the last completed 28 day cycle of medication for 44 of the residents and ten from the current medication cycle. We also looked at one MAR chart from a couple of months ago.

We found a variety of recording and administration problems [see below]. However, we did note sporadic examples of good practice, for example for one resident when a dose of a medicine was discontinued it was clear from the records where/when this was done and who made the entry on the MAR.

We found recent guidance for staff on management of diabetes for residents who use insulin. We looked at three care plans for residents with diabetes. We noticed that in the last 2 months the NHS diabetic nurse had had input into the care of residents, with some resulting changes to insulin regimes based on improved blood glucose monitoring by staff. The service will continue to use the valuable NHS resource to improve the monitoring of health for residents.

We looked at four care files for residents prescribed medicines for emotional or mental health needs. We think there can be some improvements [see below] but did note some examples of good practice, for example person centred detail for triggers of any mental health issue.

Areas for improvement

We made 7 requirements at the last inspection all of which should have been addressed prior to this inspection. Six of these remain outstanding. The seventh one related to service users' finances and will be followed up at the next inspection.

The six requirements reviewed at this inspection related to:

- * the development and regular update of individuals personal care plans,
- * the review of personal plans at least every six months in line with legal guidance,
- * an audit of incidents and clear evidence of actions being taken to reduce the likelihood of these reoccurring :
- * ensure medication was administered as instructed by the prescriber
- * ensure the medication recording system is safe, up to date and accurate

* a training plan to be in place to ensure that staff have the necessary skills to meet the care and support needs of residents.

From examination of incident records we were able to identify ten service users who had had a number of incidents recorded against their names. As a result of this we examined the personal care plans in relation to these particular individuals.

We found that there was no clarity on the admission criteria and how specific needs could be met. Given that this service is registered as a care home for people with mental health disorders, care planning was not focussed on this and failed to have enough relevant information that would guide staff to meet the needs of the service users. The care plans were weak in terms of giving clear and direct support information that would enable staff to meet service users needs and the "Aims and Objectives" of the service. This has been made part of an improvement notice dated 19 December 2012..

From the personal care plans examined we found that in the main all had behavioural charts (ABC charts) recording behavioural patterns but these did not follow into a constructive plan or protocol to try and prevent or divert behaviours. There was no clear written evidence of specific de-escalation techniques, that could be used or any evidence to suggest that staff considered how to manage the situation after it had happened. Staff were not involved in any de-briefing and evaluation of the incident. There was no evidence to suggest that service users were being consulted on the impact of this behaviour and on agreements as to how it could be prevented and managed.

There was evidence of medical assessment being sought in relation to increases in some service users' level of violence and aggression but the only change to care planning recorded as a result of this was that medication had been reviewed. "As required medication" (PRN) was prescribed for individual service users as part of a management of behaviour strategy. However, there were no protocols in place to direct staff on how to decide when to use this strategy to prevent incidents rather than administering PRN's after an incident (see requirement 1).

From the plans examined we could still evidence that these were not being reviewed at least once every six months in line with legal guidance. This has been made part of an improvement notice dated 19 December 2012.

Once again we noted a high volume of incidents and accidents that resulted from violent and aggressive behaviour of service users. Some patterns and contributing factors emerged such as dependency of service users on smoking and the need to budget the supplies of cigarettes therefore causing frustration and aggressive behaviour. However, the service was still not routinely carrying out audits of these incidents to see if it could identify triggers or possible measure to reduce the likelihood of incidents or accidents reoccurring This has been made part of an

improvement notice dated 19 December 2012. Continued failure to take actions on violent incidents puts the health and welfare of service user's and staff at risk

A number of staff spoken with advised that they and other staff were also exposed to violence and aggression from service users as they tried to manage the economy around cigarettes supplies etc. Staff told us that they often supplied items such as cigarettes from their own personal stock or purchased them for service users to try and manage the behavioural issues that could arise.

A number of staff spoken with advised that they did not routinely record incidents where they were either threatened or actually physically assaulted by service users.

The service has four double bedrooms. There was no evidence to show whether service users were being asked to share a room prior to their admission. There was no information indicating whether those currently sharing a room were happy to continue to share or had been asked if they wished to move to a single room when one was available.

The National Care Standards for Care Homes for People with mental health problems Standard 4 Your Environment indicates that by 2007 those service user's who move into an existing care home 'will be able to have a single room if you want'. The previous regulating body provided guidance in 2006 (still relevant) around single bedrooms in care homes. This stated that people should have the choice about whether they shared a bedroom or not. This should include seeking consent from the service user that he was happy to share a room or, where he or she did not have capacity to do this, seek this consent from a relative. Currently the service did not record service users' wishes with regard to their request for a single or double room.

We saw clear evidence of poor practice in this area where one service user had been moved from a single room to a shared room. That individual did not have capacity to consent to such a move. From discussions with staff it was apparent that this move took place so that the service could admit another service user who required a single bedroom. There was no indication that this arrangement had been discussed with the person who was already in the double room. From the information contained in the personal care plans of both individuals it was clear that they were not compatible to share. This was acknowledged by staff. The dignity of both people was not promoted as there was no screening available to ensure privacy when personal care tasks were being carried out (see requirements 2 & 3).

Our Pharmacy Adviser identified the following areas for improvement;

It is important that medicines and devices are stored properly to ensure they work in the way they are intended. We identified a number of medicine storage problems in the home including medicines not stored in accordance with guidelines, gaps in monitoring storage conditions, and old and unlabelled dressings stored in the service

(including one dispensed over two years ago) This has been made part of an improvement notice dated 19 December 2012. (See recommendation 1).

It is important medicines are administered in a safe and dignified way to ensure the health and welfare of residents. We identified that medicines for one resident were prepared and left in the medicine trolley for administration at a later time. This is not a recommended practice and can lead to accidental mix-ups and errors. The records show a medicine that should be taken before food or separate from other medicines being given at same time as other medicines throughout the medication cycle. This has been made part of an improvement notice dated 19 December 2012. (See recommendation 1).

When we looked at the MAR charts we found a number of medicine recording and administration issues, including medicines not given as prescribed, medicines not given because they were out of stock, and gaps in the administration of regular medicines. In some of the cases above the date of running out of stock of the medicine could have been predicted up to two weeks in advance. This has been made part of an improvement notice dated 19 December 2012. (See recommendation 1).

Poor and ambiguous medication recording can lead to poor care. When we looked at the MAR charts we found a number of medicine recording and administration practices that caused us concern including poor handling of dose changes, gaps in the audit trail of medicines received, used and disposed off, and double recording of one medicine for a day and a half. The recording of medication quantities carried forward from the previous cycle of medication was poor, and it was not always clear from the records if a medicine was still in use or had been previously discontinued. This has been made part of an improvement notice dated 19 December 2012. (See recommendation 1).

In line with past findings where audits were being carried out on personal care plans and deficits identified there was little evidence to show that staff were then addressing the areas highlighted. This continues to questions the purpose of these audits if there is no indication that any follow up work is being carried out (see recommendation 2).

We made a requirement that a detailed staff training plan had to be developed for the coming year. This plan needed to take into account the care and support needs of the service user group to ensure that all staff had the necessary skills and experience to support individual service users with all aspects of their care and support. A plan had not been drawn up and training had been sporadic. There was little evidence to show that the staff team had the necessary skills and training to meet the care and support needs of those living in the home. This has been made part of an improvement notice dated 19 December 2012.

Our Professional Adviser Infection Prevention and Control noted that during the inspection a number of agency staff were employed to provide care. However these staff did not appear to know which service users, if any, had infection prevention and control issues (see recommendation 3).

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 3

Number of recommendations: 3

Requirements

1. The provider must ensure that whenever a sedative or tranquilising drug is used to help control restlessness or other emotional/mental health needs, the care plan should contain details of:
 - * the person's symptoms of disturbance,
 - * what is likely to cause/trigger this behaviour
 - * how this is best managed for that person.
 - * current medication used to manage the care need and the criteria for its use
 - * when the medication's effectiveness will be reviewed by the prescriberThis is in order to comply with SSI 2011/210 Regulation 4 (1)(a) - a requirement to make proper provision for the health and welfare of people. The following National Care Standards have been taken into account in making this requirement: National Care Standards - Care Homes for People with mental Health Problems 5.12, 6.1, 14.8, 14.9 and 15.8
Timescale for implementation: 1 week from receipt of this report.
2. The provider must not move service users from their existing bedrooms in order to facilitate admissions to the home. Where consideration is being given to moving a service user's bedroom this must be fully discussed with the individual and/or his representative, including his social worker, and decisions agreed clearly recorded. This is in order to comply with SSI/2011/210 Regulation 4(1)(b) - a requirement that the Providers shall provide services in a manner which respects the privacy and dignity of service users. Timescale for implementation: 1 week from receipt of this report
3. The service must ensure that where people have to share a bedroom that they agree to this and that they ask whether that person wishes to remain in a double room or have the choice to move to a single room when one becomes available. This is in order to comply with SSI/2011/210 Regulation 4(1)(b) - a requirement that the Providers shall provide services in a manner which respects the privacy and dignity of service users. Timescale for implementation: 1 week from receipt of this report

Recommendations

1. The service provider should ensure medicines are managed according to recognised best practice. To do this they should ensure that:
 - * where a medicine has a fixed shelf from date of opening, that staff record a date that the product was first opened or a date beyond which it should not be used.
 - * where a product is no longer required this should be returned to the pharmacy for disposal
 - * medicines are not put out in advance of administration in medicine pots and left in the medicine trolley
 - * medicines are given only to the resident for whom they were prescribed
 - * all handwritten entries on MAR charts should be signed and dated by person making the change, and referenced to indicate where the handwritten information was obtained, or the authority for any change of dose.
 - * the service should liaise with the supplying pharmacy to ensure that the MAR chart lists only the current items required by the resident.
 - * where there are instructions such as "5 or 10ml", "one or two" the actual dose given should be recorded.

National Care Standards Care Homes for Older People 5.12, 15.6, 15.7 and 15.9

2. The provider should ensure that where it undertakes personal care plan audits and identify issues for action that it follows through on these to ensure that staff have carried out the work identified to improve the documentation. National Care Standards: Care Homes for people with mental health problems Standard 6 Personal Plans (repeat recommendation)
3. The provider should ensure that procedures are in place to ensure that all new staff including agency are made aware if any service users had infection prevention and control issues. National Care Standards: Care Homes for people with mental health problems Standard 14 Keeping well Healthcare and Standard 5 Management and Staffing Arrangements.

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 1 - Unsatisfactory

Statement 2

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

Service strengths

We found this service to be performing at an unsatisfactory standard in relation to this Quality Statement.

A Care Inspectorate Adviser Infection Prevention and Control carried out part of the inspection in relation to infection control. This identified the following;

Visitors toilets inspected were found to be clean and there was liquid soap, disposable paper towels, pedal bin and a lined sanitary bin available for use. Toilets were reportedly checked twice daily for cleanliness

External contracts are in place for the uplift of waste products such as municipal, hygiene and clinical waste, laundering of bed sheets and for maintenance of laundry equipment.

A maintenance man who checks communal areas daily is employed by the service provider. Domestic services staff photocopy daily room checks recording sheets which should identify maintenance issues and pass these on to him for action.

Supplies of disposable gloves, aprons and water soluble membrane bags for fouled/infected laundry were seen and all items were being used appropriately by staff. This addresses a requirement previously made in relation to this area.

Areas for improvement

A number of concerns were highlighted at this inspection relating to the safety of the environment for residents and visitors. These include following:

* Inadequate supply of hot water throughout the building known as H1. We were informed that one of the hot water tanks in the building needed to be repaired. There was no timescale available for this work to be done despite the problem being identified a number of weeks prior to this visit. A few service users informed up that they did not have hot water in their rooms and that his affected their ability to see to their personal hygiene needs, including shaving

- * Although checks had commenced on hot water outlets across both buildings the records reflected the handyman only checked random outlets rather than routinely checking all outlets. As these are all fitted with individual thermostatic controls it is important that all outlets are checked regularly to ensure water temperatures are maintained within safe limits
- * There was no evidence made available to show that where hot water temperatures were recorded as being low that any action was taken to rectify this;
- * Checks had commenced on bed rails used in the home. The documentation states that these should only be checked every six months. Given the high risk factors involved in using such an aid the service should be checking these regularly to ensure that they remain safe to be used. Employers should ensure that all employees who are responsible for selecting, fitting and checking bed rails have received adequate training. Other staff, such as care assistants and domestics who make beds and help service users in and out of bed may also remove and replace bed rails and, if so, will need appropriate information and instruction.
- * Checks were being carried out on bedroom windows to ensure that appropriate window restrictors were in place to limit the likelihood of a service user falling out of the window. These checks highlighted that a number of windows were currently without restrictors. They did not highlight what actions were being taken to rectify this or if risk assessments had been carried out to reduce any risks to service users (see requirement 1)

At the last inspection we highlighted that the service needed to review the use of the accommodation especially in relation to key areas where high incidents were recorded. The service could not evidence that it had taken any action in this area. As a result we again found that the environment continued to have an impact on where incidents occurred. A significant number of these records indicated four main areas within the home; the designated smoking rooms and treatment rooms in both buildings (see recommendation 1).

The atmosphere in the smoke rooms was fairly dense with smoke despite the service having improved ventilation in this area. This was due to the high number of service users smoking at the one time. These areas were flash points for behavioural outburst usually over cigarettes and disputes over seating arrangements.

The smoking areas were not environmentally friendly and staff supervised these rooms, therefore putting their health and welfare at risk. Guidance from the Scottish Government clearly states that staff should not normally be required to work in designated smoking rooms. If they have to enter them, then their time of exposure to second-hand smoke must be kept to a minimum. Staff with pre-existing conditions exacerbated by second-hand smoke e.g. asthma, should not be asked to enter them at all. There was no evidence that the provider had taken this guidance into consideration or carried out appropriate risk assessments in relation to staff entering these areas.

Service users and staff were frequently victims of violent outbursts and aggression. This affects the health and welfare of both and gives grave concern for personal safety and security. As stated under quality statement 1.3 there was evidence of under reporting and recording of these assaults, especially on assaults against staff.

Our Adviser on Infection Prevention and Control identified the following areas for improvement;

We saw dirty and dusty extractor fans within toilet areas and the hairdressing room, some dirty tables and chairs within one dining area, very dusty dehumidifier, dirty equipment, such as basins, mirrors, hair rollers and free standing fan within the hairdressing area, one service user's room had faecal contaminated items such as bedding, commode and environment, the store near the conservatory had wheelchairs and dirty weighing scales. Domestic cleaning practices by cleaning and care staff and use of equipment and chemicals did not always reflect best practice. The domestic service room was dirty and wet. Written policies and procedures were not available to direct staff practice in this area. This was discussed with the newly appointed housekeeper who started working on the problem during the inspection. It would appear that some items are not covered on cleaning and maintenance schedules and this is leading to some of the failures in cleaning identified above.

We saw a cracked hand wash sink, rusty exterior of fridge and damaged cupboard door handle in one dining room, rusty hand rail in one service users' room, broken liquid soap dispenser in one treatment room, radiator top and part of the flooring were missing in the games room, extractor fan was not working and a broken door was seen in the hairdressers area and a broken toilet seat fitting was identified in a service user's room. Damaged items cannot be effectively cleaned and may represent a danger to the health and well being of service users, staff and visitors (See requirement 2).

The service did provide liquid soap for hand washing but a top up system was in place. This represents a risk of infection and is not in keeping with best practice guidance for Hand Hygiene produced by Health Protection Scotland 2012.

In some areas, such as the laundry, domestic services area, sluice and treatment room there are no designated hand wash sinks for staff to wash their hands after handling dirty items or equipment or before preparation of clean equipment or medications.

Sluice facilities within the service were variable and did not reflect the national guidance on provision of sluice facilities. One sluice did not provide an automated washer/disinfector resulting in staff having to wash used sanitary ware by hand which is a potential risk of infection due to droplet and aerosol contamination of the environment, staff and clean equipment to be used by service users. This sluice also lacked designated hand wash sink for staff to wash their hands after cleaning used sanitary ware. In another sluice an automated machine was present but was reported

as not having been maintained for the previous three years (see requirement 3)

Some foods such as bottles of sauces were not stored in the fridge as advised by the product manufacturer and Food Hygiene Regulations. Marmalade was stored in an open dish. Breakfast cereal in one area was stored a floor level which is not good practice (see recommendation 2)

Within a treatment room a random selection of sterile products were checked and items with a manufacturers' expiry date of 07-2012 were found. This was highlighted to staff who immediately disposed of them (see recommendation 3).

The newly appointed service manager advised that he was trying to develop new policies and procedures for infection prevention and control that would be appropriate to the type of service users, the environment and facilities available. A copy of a proposed document was given to the adviser for comment and feedback will be provided at a later date. The adviser has offered support to the service manager, if requested.

The management of waste did not reflect manufacturers' and national guidance. Sharps bins were dirty, not of an appropriate size for the needs of the service, did not identify the name of site or assembler, date of assembly or have a temporary closure in place when not in use. Use of orange waste bags in some bins was inappropriate, confusing for staff and an unnecessary expense.

An external contract for Legionella control, monitoring and treatment was not known to be in place but the cleaning of shower heads was reported done by the domestic staff (see requirement 4).

The current domestic audit tool does not provide adequate information on time of day the audit was conducted, identification of what specific areas such as bathroom 1,2, or 3s, toilets or service user room numbers have been audited, number of areas/ items audited e.g. 10 out of 80 or how many staff had their practices observed.

Development of future audits should be mainly based on observation of practices and problems identified and actions taken. We will examine progress in this area at future inspections.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 4

Number of recommendations: 3

Requirements

1. The provider must ensure that they take action to address the issues highlighted above in relation to the accommodation. This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4 (1) (a) and (d), Regulation 10 (1)
Timescale: 6 weeks from receipt of this report.

2. The service provider must ensure that all equipment is clean and fit for purpose. must include

- i) regular checks by all care staff for cleanliness of service user's personal care items and actions to be taken by care staff when issues are identified
- ii) repair or replacement of all damaged surfaces and equipment
- iii) cleaning of dirty equipment such as extractor fans, light fittings, hairdressing equipment and facilities.

iv) development of written cleaning and maintenance procedures, records of achievement and clear information on who clean or maintains what, when and how

v) provision of training for staff on any changes resulting from the above points and evaluation of implementation to include actions required when problems are identified

This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4 (1) (a) and (d), Regulation 10 (1), Regulation 15 (b) (i)

Timescale: 6 weeks from receipt of this report.

3. The service provider must develop and submit an action plan with proposed dates for the upgrading of sluice and other staff areas. This must include

i) consideration for layout and provision of appropriate sluice facilities in line with national infection prevention and control guidance documents.

ii) provision of appropriate hand wash sink with non hand operated taps within areas such as sluices, domestic services room, treatment room staff and the domestic services areas.

This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4 (1) (a) (d) and Regulation 10 (1) Fitness of premises

Timescale: 4 weeks from receipt of this report

4. The service provider must ensure evidence based infection prevention and control policies and procedures are developed and implemented. This will also include:

i) waste management including use and management of sharps bins

ii) control, monitoring and if required treatment of Legionella

iii) internal provision of training on the above documents when finalised

iv) implementation and monitoring of implementation to include actions to be taken when problems are identified.

This is in order to comply with: The Social Care and Social Work Improvement

Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210
Regulation 4 (1) (a) (d) and Regulation 15 (b) (i)
Timescale:4 weeks from receipt of this report.

Recommendations

1. The provider should undertake a full review of the accommodation and develop an action plan detailing how it plans to improve the communal areas in order to create comfortable and relaxing environment for people to live in. Appropriate timescales for implementation should be attached to this plan. National Care Standards, Care Homes for People with Mental Health Problems: Standard 4: Your Environment.
2. The service provider should ensure that all food is stored appropriately and in accordance with the manufacturer's instructions and Food Hygiene Regulations. National Care Standards Care Homes for People with Mental Health Problems: Standard 13- Eating well
3. The service provider should ensure that there is a system in place to regularly check sterile products are within the manufacturers use by date. National Care Standards Care Homes for People with Mental Health Problems: Standard 14- Keeping well - healthcare

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

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

We found this service to be performing at a weak standard in relation to this Quality Statement.

The new manager was currently reviewing the service's policy in relation to recruitment. This addresses a recommendation made at the last inspection. We will review the content of this policy at the next inspection to ensure that it is appropriate and fit for purpose.

In line with past findings, staff files examined at the inspection held relevant recruitment information on staff, including application forms and references. Staff were initially employed on a probationary period. At the end of this time an appraisal took place to ensure that the member of staff was suitable to remain in employment.

Staff recently employed had undergone a new induction programme. New staff spoken with indicated that this had been comprehensive and, following this, they had been linked to a mentor to work with through the remainder of their probation. This addresses a requirement made as a result of a recent regulatory visit to the service.

As a result of comments made at the last inspection regarding continuity of staff in both buildings, the provider had taken action to ensure that there were designated staff teams for both buildings. Staff advised that they thought this had helped to build up some continuity in care and ensured that named nurses and key workers are working with their key service users when on duty.

As previously stated the service had policies in relation to staff supervision and appraisals. The service had a detailed and comprehensive supervision format for staff that looked at a range of areas including not only the needs of the individual staff member but also the needs of the service.

The service had policies in relation to adult and child protection.

Areas for improvement

At the last inspection we made a requirement in relation to the safe recruitment of staff. We sampled recruitment files from July 2012 and continued to evidence that the service was still not always following best practice when it came to recruiting staff. This included relevant police checks being taken up /returned prior to employment. It was not always evident from the sample of files examined that all new staff employed had these checks in place before commencing employment. There was no evidence that the provider had carried out risk assessments or arranged for these new staff to be supervised until these checks came through. The service was therefore not following Best Practice Guidance, including guidance issued by us, in relation to ensuring safe recruitment of staff (see requirement 1). The manager advised that from the 16 October 2012 no member of staff had been recruited without the relevant checks being carried out. We will follow this up at the next inspection.

At the last inspection we highlighted that staff had previously had training in relation to adult support and protection and had stated that the service needed to ensure that this training was ongoing to ensure that all staff were aware of their roles and responsibilities in this area. No additional training had been provided to staff. However, given the high volume of adult support and protection issues reported by the service it would be beneficial for staff to receive refresher training in this area. The manager advised that the local authority had agreed to provide training early in 2013. We will follow this up at the next inspection.

We previously highlighted concerns over the values and attitudes of a number of staff. We made a requirement that the provider ensured that staff received appropriate training in relation to values and to monitor staffs practice in this area. This training had not been delivered nor was there evidence that it was planned. This is an area that the service needs to address to ensure that staff clearly value and respect people as individuals (see requirement 2).

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. The provider must be able to demonstrate that when staff are recruited that all necessary checks have been carried out and results obtained prior to them commencing employment. In exceptional circumstances the provider must put appropriate measures in place to supervise staff until the relevant police checks have been carried out. This must include any staff being reemployed by the service.

This is in order to comply with SSI 2011/210 Regulation 9 - Fitness of employees
Timescale for implementation

2. The provider must ensure that staff treat and value service users as individuals. All staff must receive appropriate values-based training. The service must monitor staff practice in relation to this area. This is in order to comply with SSI 2011/210 Regulation 15(b) (l) - a requirement that the Provider shall ensure that persons employed in the provision of the care service receive training appropriate to the work they are to perform.

Timescale for implementation: 2 months from publication date of this report
(repeat requirement)

Statement 3

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

Service strengths

We found this service to be performing at a weak standard in relation to this Quality Statement.

We found that there had been limited training since the last inspection. Training that had taken place included: some moving and handling, managing challenging behaviours and fire safety.

A number of staff employed were recognised trainers or Champions in a number of areas including non-violent crisis intervention, infection control, adult support and protection and moving and assisting.

The new manager had had one meeting with all staff. Staff spoken with felt that this had been a positive meeting and that the manager had set out their plans for the coming months.

Areas for improvement

Whilst we found there was some evidence that limited training had taken place there was no staff training programme in place. There was no system in place to show what training staff had had or where the gaps were in individuals training. This meant that the service could not show that the staff team had the necessary skills and training to work with the variety of care and support needs of those using the service. Staff spoken with commented on the need for additional training particularly around management of behaviours that challenge and possibly the use of restraint (see requirement 9 under Quality Statement 1.3).

The manager was able to show that the service was in the process of devising a training matrix that would highlight training undertaken by staff. From this the service

would be able to identify where the gaps were and devise a relevant training plan for the service.

It was clear from discussions with staff that mandatory training including moving and handling needed to be prioritised and clear timescale for its completion set. A requirement had previously been made in relation to this area that remained outstanding and will therefore be repeated (see requirement 1). It is disappointing that despite the service having a range of internal trainers, including a moving and handling instructor that this group of staff have not been utilised effectively by the provider to ensure that staff have the skills to address service users support needs.

Timescales for the completion of training in management of challenging behaviours was also needed. This was to ensure that all staff completed this training timeously and to ensure that it was then implemented consistently by all staff when working with service users.

As highlighted under Quality Statement 2.2 there are a number of areas where the service lacks in terms of addressing infection control and prevention issues. We found that there was a lack of training in this area for staff and have made a requirement in relation to this (see requirement 2).

Despite the service having clear policies with regard to staff supervision and appraisals these had not taken place for sometime. It is clear that these need to be fully established to ensure that management can not only use this to discuss training needs of individual staff but also to look at and address issues in relation to staff practices as needed

The service would benefit from obtaining a copy of 'The Framework for Continuous Learning in Social Services' the Scottish Social Services Council (SSSC) publication for information and guidance on ongoing staff training and development. Consideration should be given to how this could be implemented for staff in the service.

The service was reviewing and updating various policies and procedures to reflect best practice. The management would then need to consider how these should be implemented in the service and how they would ensure that staff were kept informed of the updates and any changes to practice needed as a result.

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. The provider must ensure that all staff employed in the service receive appropriate manual handling training for the job they are employed to do. In addition all staff must have an update of this training on a regular basis.
This is to comply with the SSI 2011/210 Regulation 15 (b)(i) Staffing. In making this requirement National Care Standards Care Homes for people with mental health problems Standard 5.1, 5.2, 5.9 Management and staffing arrangements have been taken into account.
Timescale: Within seven days of receipt of this report to commence manual handling training and on an ongoing basis thereafter.
2. Infection prevention and control training must be provided to all staff to ensure a healthy environment and reduce the potential for infection. This must include
 - (i) all aspects of cleaning such as safe practices, use of appropriate chemicals and equipment and reporting of any concerns
 - (ii) correct segregation of different waste categories and management and use of sharps bins
 - (iii) hand washing for staff and service users
 - (iv) evaluation of training and implementation of practices
 - (v) identification of action to be taken to address practice failures or deficiencies in training

This is in order to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4 (1) (a) and (d) and Regulation 15 (b) (i) Timescale: Within one month of receipt of this report

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 2 - Weak

Statement 2

We involve our workforce in determining the direction and future objectives of the service.

Service strengths

We found this service to be performing at a weak standard in relation to this Quality Statement.

The Company had policies in relation to staff appraisals and supervision, which set out how often these should take place.

The new manager (only in post since September 2012) had recently set up daily 'flash' meetings with heads of departments to ensure that where any issues were raised that these could be addressed quickly. This included staff from care, maintenance and housekeeping.

The new manager knew about his responsibility to notify the relevant bodies of any staff misconduct or disciplinary action.

Areas for improvement

The provider has responsibility to ensure that the service operates within legal requirements. This means they must ensure that the service address any requirements made by us within the timescales set. The findings from this inspection highlight that the provider has failed to ensure that the requirements made at the last inspection have been met. The Provider must have systems in place to identify areas for improvement and take prompt action to rectify these (see requirement 1).

As the new manager had only been in post a number of weeks prior to this inspection staff spoken with felt it was too early to comment on how he would take things forward.

A number of staff spoken with advised that they did not feel supported in relation to violent incidents that occurred in the home. They were not offered the appropriate support to deal with these incidents or to consider how they could move forward. As reported under Quality Statement 2.2 staff were not always reporting violent incidents against them so we were unable to quantify how many incidents there were or how

these were dealt with by management in terms of their responsibilities towards the safety of the staff team.

As previously stated staff supervisions and appraisals were not taking place this meant that staff had no opportunities available to have a say on the service or be involved in determining its direction or future objectives (see recommendation 1).

There was no effective learning culture in the home. Management do not provide staff with access to, or information about, learning resources that ensure they keep up to date with changes in the care sector. In order to address this the provider should develop a resource library containing both up to date training materials as well as best practice guidance relevant to the care home. Local management must ensure that learning and development becomes a regular feature of team meetings and individual development (see requirement 2)

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 1

Requirements

1. The provider must set up systems that allow them to have a clear overview of what is happening in the service. An action plan must be developed detailing any improvements identified. This must be prioritised, identify who is responsible for taking action and set clear and realistic timescales. The Provider must take responsibility to ensure that the plan is implemented and completed within the timescales set. This is in order to comply with: SSI 210/2011 Regulation 4.1 (a) - Welfare of users Timescale for implementation: One week from receipt of this report
2. The provider must develop and maintain an effective learning and development frame work in the service. This must include staff being able to access relevant learning resources as needed. . This is in order to comply with: SSI 210/2011 Regulation 15 (a) &(b) Staffing
Timescale for implementation: One month from receipt of this report

Recommendations

1. The provider should develop ways that allow all staff to have an input in determining the direction and future objectives of the care service. This information should be used to assist with the formation of the services development plan. National Care Standards: Care Homes for Adults with Mental Health Problems Standard 5 Management and Staffing Arrangements.

4 Other information

Complaints

One complaint had been partially upheld since the last inspection. This related to the following areas:

- * Staff delayed attending to a service user's wounds after the dressing became contaminated by urine.
- * There was no personal protective equipment (PPE) in place for staff when attending to service users who had infections such as MRSA.
- * There was inadequate equipment for staff to manage a service user's leg wounds.
- * Manual handling practice was poor.
- * Recruitment procedures were not followed adequately.
- * New staff do not have adequate induction.

As a result of this investigation the following four requirements and one recommendation were made. We have commented on these within the relevant sections of the report.

Enforcements

We have taken no enforcement action against this care service since the last inspection.

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 SCSWIS re-grading the Quality Statement within the Management and Leadership Theme as unsatisfactory (1). This will result in the Quality Theme for Management and Leadership being re-graded as Unsatisfactory (1).

5 Summary of grades

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

6 Inspection and grading history

Date	Type	Gradings	
17 Oct 2012	Re-grade	Care and support	2 - Weak
		Environment	Not Assessed
		Staffing	Not Assessed
		Management and Leadership	Not Assessed
21 Jun 2012	Unannounced	Care and support	3 - Adequate
		Environment	3 - Adequate
		Staffing	2 - Weak
		Management and Leadership	Not Assessed

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