# Item: 7

**Policy and Resources Committee: 28 November 2023.**

**Registered Services within Orkney Health and Care – Inspection Assurance.**

**Report by Chief Officer, Orkney Health and Social Care Partnership.**

## 1. Purpose of Report

To present the second six-monthly assurance report on inspection activities for registered services within Orkney Health and Care.

## 2. Recommendations

The Committee is invited to scrutinise:

### 2.1.

The inspection activity for registered services within Orkney Health and Care, for the period 1 May to 31 October 2023, as detailed in section 4 of this report, in order to obtain assurance that action plans have been submitted to the Care Inspectorate and are being progressed where appropriate.

## 3. Background

### 3.1.

The Care Inspectorate is the national regulator for care services in Scotland and inspects services across Scotland to ensure services are meeting the right standards. There are a range of services the Care Inspectorate requires registration for, including the following:

- Childminding.
- Daycare of children.
- Care homes for adults.
- Care at home.
- Support Services.
- Housing Services.
- Adoption.
- Care homes for children.
- Fostering.
- Nursing agency.
- Offender accommodation.
- Schoolcare accommodation.

- Secure care.

### 3.1.1.

Further detail on the definitions of each of these services can be found here. Any care service must be registered, or they cannot operate.

### 3.2.

The Care Inspectorate also works with partner agencies, including Healthcare Improvement Scotland; His Majesty's Inspectorate of Constabulary in Scotland; and Education Scotland, to scrutinise how well different organisations in local areas work to support adults and children.

### 3.3.

The Care Inspectorate routinely visits all care sector settings, and these can be either announced, announced (short notice) or unannounced visits.

### 3.4.

The Care Inspectorate uses a six-point scale when evaluating the quality of performance across quality Indicators:

| | | |
|---|---|---|
| 6. | Excellent. | Outstanding or sector leading. |
| 5. | Very Good. | Major strengths. |
| 4. | Good. | Important strengths, with some areas for improvement. |
| 3. | Adequate. | Strengths just outweigh weaknesses. |
| 2. | Weak. | Important weakness, priority actions required. |
| 1. | Unsatisfactory. | Major weaknesses – urgent remedial action required. |

## 4. Inspections

### 4.1.

The table below details the services which have had an inspection by the Care Inspectorate in the period 1 May to 31 October 2023.

| Service | Inspection Publication Date | Grade | | | | |
|---|---|---|---|---|---|---|
| | | Wellbeing | Leadership | Setting | Staffing | Care and Support |
| Kalisgarth Care Centre (Day Services). | 06.06.23. | 5. | 3. | N/A. | N/A. | N/A. |
| Kalisgarth Care Centre | 06.07.23. | 4. | 3. | N/A. | N/A. | N/A. |
| Sunnybrae Centre | 13.07.23. | 3. | 3. | N/A. | 2. | 3. |
| Braeburn Court | 14.07.23. | 3. | 3. | N/A. | 3. | 3. |
| Care at Home | 10.08.23. | 4. | 4. | N/A. | N/A. | N/A. |

## 4.2. Kalisgarth Care Centre – Day Services

An unannounced inspection was undertaken in respect of the day services at Kalisgarth Care Centre on 26 April 2023.

**4.2.1.**

As part of the inspection activity, various information was reviewed including the previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. The Inspector also spoke with a number of people who used the service including family/legally appointed guardians, staff and management as well as observing practice and daily life.

**4.2.2.**

The key highlights within the Inspection Report published on 6 June 2023, attached as Appendix 1 to this report, are:

- Staff were familiar with people's needs and preferences.
- People were respected and valued.
- People enjoyed a range of meaningful activities.
- People receiving care and support advised that they were very happy with the service.

**4.2.3.**

Areas identified for improvement:

- In order to ensure that people have confidence in the staff supporting them, the provider should ensure staff access training appropriate to their role, and apply their training in practice. This should include, but is not limited to, training in adult protection and dementia care.

**4.2.4.**

There was one area identified for improvement from the previous inspection which has not fully been addressed:

- Fully embed quality assurance processes across the operational arrangements of the service to monitor, measure and improve the quality of care and support and outcomes.

**4.2.5.**

An action plan to address both areas for improvement has been developed and submitted to the Care Inspectorate. This will be routinely monitored to ensure progress.

## 4.3. Kalisgarth Care Centre – Housing Support Services

An unannounced inspection was undertaken in respect of housing support services at Kalisgarth Care Centre.

**4.3.1.**

The inspection activity took place between 26 June and 6 July 2023. As part of the inspection activity various information was reviewed including the previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. The inspector also spoke with some individuals who are using the service, some family members, staff and management. As well as observing the practice and daily lives.

**4.3.2.**

The key messages within the Inspection Report published on 6 July 2023, attached as Appendix 2 to this report, are:

- The staff were familiar with people's needs and preferences.
- People were respected and valued.
- People enjoyed a range of meaningful activities.
- People receiving care and support advised that they were very happy with the service.
    - “I wouldn’t want to live anywhere else”.
    - “I wouldn’t change a thing, the girls are great”.

**4.3.3.**

Areas identified for improvement:

- Staffing levels needed improved.
- Fully embed quality assurance processes across the operational arrangements of the service to monitor, measure and improve the quality of care and support and outcomes.
- External management support needed improved.

**4.3.4.**

Following the feedback session from the Care Inspectorate with the management team and the finalised inspection report, an Action Plan to address the improvement areas was developed and submitted to the Care Inspectorate.

## 4.4. Sunnybrae Centre

An unannounced inspection was undertaken for the Sunnybrae Centre, in respect of both housing support services and support services.

**4.4.1.**

The inspection activity took place between 5 and 13 July 2023. As part of the inspection activity various information was reviewed including the previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. The Inspector also spoke with a number of people who used the service including family, staff and management, as well as observing the practice and daily lives.

**4.4.2.**

The key messages identified by the Care Inspectorate in the Inspection Report published on 13 July 2023, attached as Appendix 3 to this report, are:

- Individuals supported were happy with their experiences.
- The service worked with external groups to enhance the experiences of individuals.
- The manager had made improvements to the quality assurance system in the service.
- The service continued to find staff recruitment and retention a challenge.

**4.4.3.**

Areas identified for improvement:

- Management availability within the service needed to improve.
- Ensure appropriate levels of skilled and experienced staff.
- Ensure staff have the appropriate knowledge and skills to fulfil their roles.

**4.4.4.**

This is a follow up inspection from the one undertaken earlier in 2023 which shows progress in addressing the areas of improvement and that work continues. Pages 7 to 10 of the Inspection Report, attached at Appendix 3, details progress with actions met within the timescales given.

**4.4.5.**

Following receipt of the informal feedback an action plan to address the areas for improvement has been developed and submitted to the Care Inspectorate. This will be routinely monitored to ensure progress.

## 4.5. Braeburn Court

An unannounced inspection was undertaken for the Braeburn, in respect of both housing support services and support services.

**4.5.1.**

The inspection activity took place between 4 and 14 July 2023. As part of the inspection activity various information was reviewed including the previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. The Inspectors also spoke with a number of people who used the service as well as one of the service users' representatives, staff, management and visiting professionals, as well as observing the practice and daily lives. During this inspection the Inspectors reviewed progress since the inspection concluded in March 2023.

**4.5.2.**

The key messages identified by the Care Inspectorate in the Inspection Report published on 14 July 2023, attached as Appendix 4 to this report, are:

- Interim management arrangements had stabilised the service.
- Staff benefited from improved training and access to management support.
- Personal plans had been updated and reflected people's needs and preferences.
- Improved links with external professionals supported improved health outcomes for people.
- People benefited from compassionate support from people who knew them well.
    - "The staff are here when I need them".
    - "Staff are very caring and kind".
    - "They are willing to do anything for me".

**4.5.3.**

Areas identified for improvement:

- Quality assurance systems should be embedded and developed to ensure sustained improvement.
- A service improvement plan informed by the views of people who use the service should be developed.
- Review the activity provision to ensure access to activity in line with preferences and choices.
- Ensure effective management arrangements remain in place.

**4.5.4.**

This inspection is a follow up inspection from the previous inspection which shows progress has been made and work continues to improve. Pages 7 to 12 of the Inspection Report, attached as Appendix 4, detail that five areas of improvement have been met since the March 2023 inspection concluded.

**4.5.5.**

Following receipt of the informal feedback an updated action plan to address the areas for improvement which were identified has been developed and submitted to the Care Inspectorate. This will be routinely monitored to ensure progress.

## 4.6. Care at Home

An unannounced inspection was undertaken for the Care at Home, in respect of both housing support services and care at home services.

**4.6.1.**

The inspection activity took place between 31 July and 10 August 2023. As part of the inspection activity various information was reviewed including the previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. The Inspectors also spoke with a number of people who used the service including family, external professionals involved with people being supported, staff and management, as well as observing the practice and daily lives.

**4.6.2.**

The key messages identified by the Care Inspectorate in the Inspection Report published on 10 August 2023, attached as Appendix 5 to this report, are:

- People were satisfied with the care and support provided by the service.
    - “The lassies [care at home assistants] that look after me are great – 10 out of 10”.
    - The staff are pleasant and respectful, I have no complaints”.
- The recent management team had identified areas that required improvement and were making early progress to take the service forward.
    - “We had issues with four different staff visiting on the one day – this has improved greatly in the past month. The current carers are good at their job, they have the right skills and are kind”.
- Work had been carried out to promote consistency of care through recruitment of staff and better organisation of staff teams.
- Confidence in the management team’s ability to improve and sustain improvement within the service.

**4.6.3.**

Areas identified for improvement:

- Improvements needed to be made with communications, support plan documentation, medication administration and staff training and development.

**4.6.4.**

Following receipt of the informal feedback an action plan to address the areas for improvement has been developed and submitted to the Care Inspectorate. This will be routinely monitored to ensure progress.

## 5. Human Resource Implications

Whilst there are no direct Human Resources implications arising out of this report, it would be appropriate to note that recruitment and retention of staff across the Council and within front line care particularly continues to be a challenge. Recruitment is a key priority of the Council People Plan, with a range of actions underway to aim to improve what is a challenging national picture for recruitment within care.

## 6. Corporate Governance

This report relates to the Council complying with governance and scrutiny and therefore does not directly support and contribute to improved outcomes for communities as outlined in the Council Plan and the Local Outcomes Improvement Plan.

## 7. Financial Implications

There are no immediate financial implications arising from the recommendations contained within this report. Any action plans generated as a result of the inspection recommendations must be met from within existing approved budgets.

## 8. Legal Aspects

There are no immediate legal implications arising from the recommendations contained within this report.

## 9. Contact Officer

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## 10. Appendices

Appendix 1: Care Inspectorate Inspection Report – Kalisgarth Care Centre – Day Services.

Appendix 2: Care Inspectorate Inspection Report – Kalisgarth Care Centre – Housing Support Services.

Appendix 3: Care Inspectorate Inspection Report – Sunnybrae Centre.

Appendix 4: Care Inspectorate Inspection Report – Braeburn Court.

Appendix 5: Care Inspectorate Inspection Report – Care at Home.