care inspectorate

A quality framework for care homes for adults

For use in self-evaluation, scrutiny, and improvement support

October 2020

HAPPY TO TRANSLATE

Changes to our inspection

The Care Inspectorate are developing new approaches to scrutiny. We want to make sure inspections and our other scrutiny work, are strongly focused on assessing the extent to which people experience wellbeing, and understanding the difference care and support makes to their lives.

Since 1 April 2018, the new **Health and Social Care Standards** have been used across Scotland. They have been developed by Scottish Government to describe what people should experience from a wide range of care and support services and are relevant not just for individual care services, but across local partnerships. The Care Inspectorate's expectation is that they will be used in planning, commissioning, assessment and delivering care and support. We will use them in the decisions we make about care quality. This means that we are changing how we inspect care and support.

From 2018, on an incremental basis, we have been rolling out a revised methodology for inspecting care and support services. This is now being rolled out for care homes for adults. The changes build on approaches we have introduced in the past three years: an emphasis on experiences and outcomes for people, proportionate approaches in services that perform well, shorter inspection reports and a focus on supporting improvement in quality.

The core of the new approach is a quality framework which sets out the elements that will help us answer key questions about the difference care is making to people and the quality and effectiveness of the things that contribute to that.

The primary purpose of a quality framework is to support services to evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support. By setting out what we expect to see in high-quality care and support provision, it can help support improvement too. Using a framework in this way develops a shared understanding of what constitutes good care and support. It also supports openness and transparency of the inspection process.

We have involved people who experience and people who provide care and support in developing this quality framework. It is based on the approach used by the European Foundation for Quality Management, specifically the **EFQM Excellence Model**, which is a quality tool widely used across sectors and countries. We have adapted the model for use in care and support settings and have used the new Health and Social Care Standards to illustrate the quality we expect to see. We tested versions of this framework in about 60 care homes for older people between November 2017 and May 2018 and carried out a further 21 tests in care homes for adults in January 2019. These tests were evaluated to hear the views of people experiencing care, their carers and care providers. The tests and people's experiences of them helped us refine the framework and the way we will use it.

How is the framework structured?

The quality framework is framed around **key questions**. The first of these is:

- How well do we support people's wellbeing?

To try and understand what contributes to that, there are four further key questions:

- How good is our leadership?
- How good is our staff team?
- How good is our setting?
- How well is care planned?

Under each key question, there are three to four **quality indicators**. These have been developed to help answer the key questions. Each quality indicator has **key areas**, short bullet points which make clear the areas of practice covered by it.

Under each quality indicator, we have provided **quality illustrations** of these key areas at two levels on the six point scale that we use in inspections. The illustrations are the link to the Health and Social Care Standards and are drawn from the expectations set out in these. They describe what we may expect to see in a care service that is operating at a "very good" level of quality, and what we might see in a service that is operating at a "weak" level of quality. These illustrations are not a definitive description of care and support provision, but are designed to help care and support services and inspectors evaluate the quality indicators using the framework.

The final key question is:

- What is our overall capacity for improvement?

This requires a global judgement based on evidence and evaluations from all other key areas. The judgement is a forward-looking assessment, but also takes account of contextual factors which might influence the capacity of an organisation to improve the quality of services in the future. Such factors might include changes of senior staff, plans to restructure, or significant changes in funding. We think this an important question to ask as part of a self-evaluation of care.

In May 2020, we developed Key Question 7 to augment our quality frameworks for care homes for adults and older people. This was done in response to the COVID-19 pandemic and to meet the duties placed on us by the Coronavirus (Scotland) (No. 2) Act and subsequent guidance that we must evaluate (grade) infection prevention and control and staffing.

Key question 7 has three quality indicators and, as with all our key questions, can be used alone or in combination with any of the other key questions and quality indicators from the framework.

In each quality indicator, we have included a **scrutiny and improvement** toolbox. This includes examples of the scrutiny actions that the Care Inspectorate may use to evidence the quality of provision. It also contains links to key practice documents that we think will help care services in their own improvement journey.

How will this quality framework be used on inspections?

The quality framework will be used by inspectors instead of the older approach of 'inspecting against themes and statements'. Inspectors will look at a selection of the quality indicators. Which and how many quality indicators will depend on the type of inspection, the quality of the service, the intelligence we hold about the service, and risk factors that we may identify. It is likely that we will always inspect Quality Indicators 1.1, 1.2, 1.3 and 5.1. We will use the quality illustrations, which are based on the Health and Social Care Standards in our professional evaluations about the care and support we see.

Quality Indicator, 1.4, looks beyond the practice of an individual care service and introduces elements about the impact of planning, assessment and commissioning on people experiencing care. This is important because these practices impact on people's experiences and the extent to which they experience wellbeing. This quality indicator may help us during an inspection to find information or intelligence which is relevant to practices in commissioning partnerships, but our overall inspection evaluations (grades) will reflect the impact and practice of the care service itself.

We will provide an overall evaluation for each of the key questions we inspect, using the six point scale from unsatisfactory (1) to excellent (6). This will be derived from the specific quality indicators that we inspect. Where we inspect one quality indicator per key question, the evaluation for that quality indicator will be the evaluation for the key question. Where we inspect more than one quality indicator per key question, the overall evaluation for the key question will be the lower of the quality indicators for that specific key question, recognising that there is a key element of practice that makes the overall key question no better than this evaluation.

How will we use the six-point scale?

The six-point scale is used 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 weaknesses – priority action required
1	Unsatisfactory	Major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance which is sector leading and supports experiences and outcomes for people which are of outstandingly high quality. There is a demonstrable track record of innovative, effective practice and/or very high quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.
An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. While opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes which are as positive as possible.

An evaluation of **adequate** applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance which is evaluated as adequate may be tolerable in particular circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements must be made by building on strengths while addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes.

Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

An evaluation of **unsatisfactory** will apply when there are major weaknesses in critical aspects of performance which require immediate remedial action to improve experiences and outcomes for people. It is likely that people's welfare or safety will be compromised by risks which cannot be tolerated. Those accountable for carrying out the necessary actions for improvement must do so as a matter of urgency, to ensure that people are protected and their wellbeing improves without delay.

How can this quality framework be used by care services?

The framework is primarily designed to support care services in self-evaluation. We are working with care services and sector-wide bodies to build the capacity for self-evaluation, based on this framework.

Self-evaluation is a core part of assuring quality and supporting improvement. The process of self-evaluation, as part of a wider quality assurance approach, requires a cycle of activity based round answering three questions.

- **How are we doing?**

This is the key to knowing whether you are doing the right things and that, as result, people are experiencing high quality, safe and compassionate care and support that meets their needs, rights and choices.

- **How do we know?**

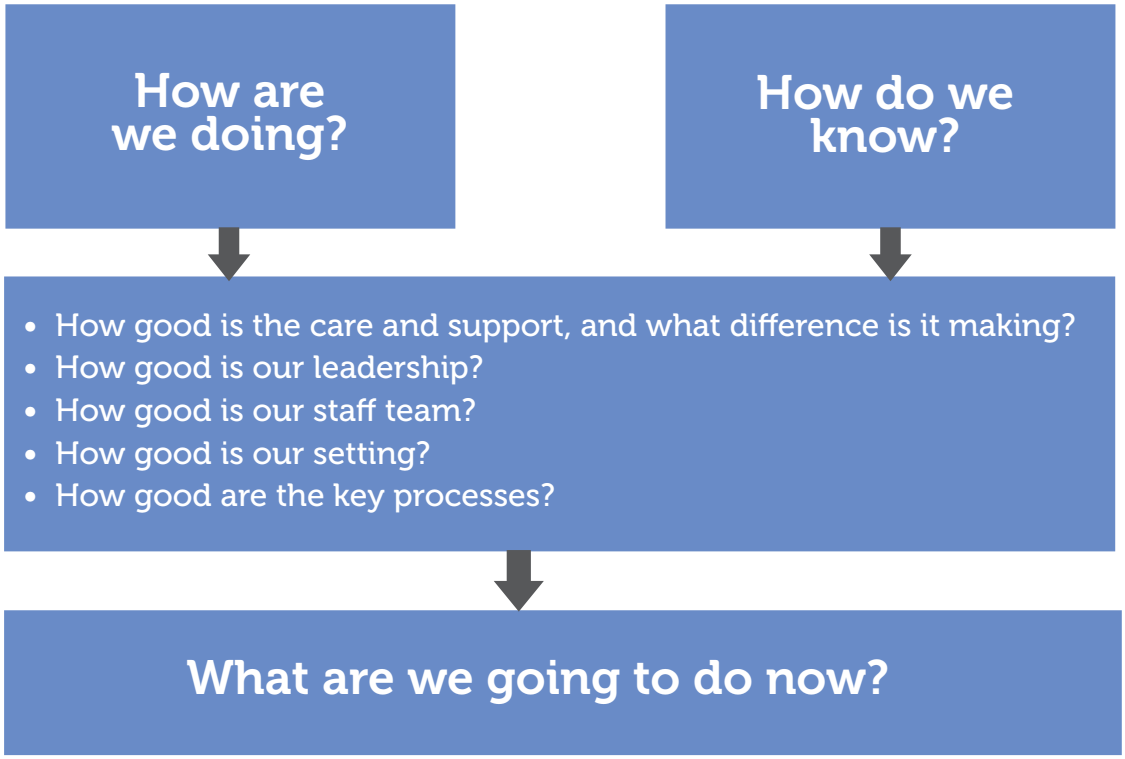
Answering the question 'how we are doing?' must be done based on robust evidence. The quality indicators in this document, along with the views of people experiencing care and support and their carers can help you to evaluate how you are doing. You should also take into account performance data collected nationally or by your service.

- **What are we going to do now?**

Understanding how well your service is performing should help you see what is working well and what needs to be improved. From that, you should be able to develop plans for improvement based on effective practice, guidance, research, testing and available improvement support.

Using this quality framework can help provide an effective structure around self-evaluation.

This diagram summarises the approach.



Irrespective of our role as the national scrutiny and improvement body, care providers will want to satisfy themselves, their stakeholders, funders, boards and committees that they are providing high quality services. We believe that this quality framework is a helpful way to support care and support services to assess their performance against our expectations of outcomes for people outwith an inspection and as part your own quality assurance. We are promoting this approach as we believe it adds value and we consider it important that care and support providers do not take actions merely to satisfy the inspection process.

The quality indicator framework

Key question 1: How well do we support people's wellbeing?	Key question 2: How good is our leadership?	Key question 3: How good is our staff team?	Key question 4: How good is our setting?	Key question 5: How well is our care and support planned?
1.1. People experience compassion, dignity and respect	**2.1.** Vision and values positively inform practice	**3.1.** Staff have been recruited well	**4.1.** People experience high quality facilities	**5.1.** Assessment and care planning reflects people's outcomes and wishes
1.2. People get the most out of life	**2.2.** Quality assurance and improvement is led well	**3.2.** Staff have the right knowledge, competence and development to care for and support people	**4.2.** The setting promotes people's independence	**5.2.** Carers, friends and family members are encouraged to be involved
1.3. People's health benefits from their care and support	**2.3.** Leaders collaborate to support people	**3.3.** Staffing levels are right and staff work well together	**4.3.** People can be connected and involved in the wider community	
1.4. People are getting the right service for them	**2.4.** Staff are led well			

Key question 6: What is the overall capacity for improvement?			
Key question 7: How good is our care and support during the COVID-19 pandemic?	**7.1.** People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic	**7.2.** Infection prevention and control practices support a safe environment for people experiencing care and staff	**7.3.** Staffing arrangements are responsive to the changing needs of people experiencing care

Key question 1:
How well do we support people's wellbeing?

This key question has four quality indicators associated with it.

They are:
1.1. People experience compassion, dignity and respect
1.2. People get the most out of life
1.3. People's health benefits from their care and support
1.4. People are getting the right service for them

Quality indicator 1.1: People experience compassion, dignity and respect

Key areas include the extent to which people experience:

- compassion
- dignity and respect for their rights as an individual
- help to uphold their rights as a citizen free from discrimination.

Quality illustrations	
Very good	**Weak**
People experience care and support with compassion because there are warm, encouraging, positive relationships between staff and people living in the care home, which help people to achieve their individual outcomes. People feel respected and listened to as their wishes and preferences are used to shape how they are supported, including if they wish to decline an aspect of their support. People experience support that promotes independence, dignity, privacy and choice. They feel connected as they are enabled to maintain and develop relationships within and outside the care home.	Staff interact with people in ways which are impersonal or abrupt. People's views and preferences are not actively sought when planning and delivering care and support. People's views and preferences are not reflected in daily practice. Care and support is delivered around routines and tasks with little regard for individual needs and wishes. The rights of people in making choices and maintaining their independence, for example, freedom of movement, are not promoted and a risk averse approach is prevalent.
People's rights are respected. They are treated fairly and staff actively challenge any form of discrimination. Where people's independence, choice and control are restricted, they are well informed about these and legal arrangements and appropriate supports are in place. Restrictions are kept to a minimum and carried out sensitively.	There are a limited range of opportunities for people to be involved in decisions about the care home. Where views are gathered, people still feel they are not listened to and there is little evidence to demonstrate how their views have been taken into account. Restrictions placed on people's choice or independence are not designed to benefit the individual, or are not linked to risk.

People are well informed about their citizenship rights, including voting. They are actively supported to exercise these rights and staff demonstrate the principles of the health and social care standards in their day-to-day practice. People are involved in decisions about the care home in ways which are meaningful to them. People feel empowered because their voice is heard, including opportunities to use independent advocacy.	Staff are unclear about the purpose of obtaining consent, or do not actively seek consent, from people or their representatives. Staff are not clear about how the principles of the Health and Social Care Standards should inform their practice. People may experience stigma or feel as though they are judged because of their circumstances.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe practice and interactions • Review how the confidentiality policy, procedure and practice is managed, such as whether all information is held confidentially and maintained by staff including during discussions • Discussion with – people living in the care home, relatives, friends, visitors, staff • Examine review / meeting minutes, action plans and evidence change in practice • Examine advocacy links and support for people and if advocates are available, speak with them • Examine how policies, procedures and practice ensure that people are not subject to discriminatio n based on protected characteristics, including disability, gender, age, sexuality • Examine policies / procedures and practice for restriction of liberty • Look at Duty of Candour records • Identify how communication support tools are used in gathering people's views and decision-makin • Consider what information the service provides about any limitations or restrictions on choice as a result of using the service – in admission or welcome documents	The Health and Social Care Standards: **www.newcarestandards.scot** Mental Health Strategy for Scotland: **https://www.gov.scot/publications/mental-health-strategy-2017-2027/** Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce: **https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf** Rights, respect and recovery: alcohol and drug treatment strategy: **https://www.gov.scot/publications/rights-respect-recovery/** The Quality Principles: **https://www.gov.scot/publications/quality-principles-standard-expectations-care-support-drug-alcohol-services/** Rights, Risks and Limits to Freedom, and Human Rights in Mental Health Services, Covert Medication, Working with the AWI Act, Decisions about Technology. All from the Mental Welfare Commission: **https://www.mwcscot.org.uk/publications/good-practice-guides** Mental Welfare Commission advice note – Hidden Surveillance **https://www.mwcscot.org.uk/media/300499/hidden_surveillance_v3.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Information from the Scottish Human Rights Commission: **http://www.scottishhumanrights.com** World Health Organisation – QualityRights: Human Rights and Recovery in mental health **https://www.who.int/mental_health/policy/quality_rights/guidance_training_tools/en/** SCLD – Using scrutiny to drive outcomes and associated resources **https://www.scld.org.uk/wp-content/uploads/2017/03/Scrutiny-Report-1.3.17.pdf** Scottish Recovery Consortium **https://www.scottishrecoveryconsortium.org/index.php?id=787** Guidance for care providers in Scotland using CCTV **http://hub.careinspectorate.com/media/758375/cctv-guidance.pdf** Charter for Involvement **https://arcscotland.org.uk/involvement/charter-for-involvement/**

Quality indicator 1.2: People get the most out of life

Key areas include the extent to which people:

- make decisions and choices about how they spend their time
- are supported to achieve their wishes and aspirations
- feel safe and are protected but have the opportunity to take informed risks.

Quality illustrations	
Very good	**Weak**
People are recognised as experts in their own experiences, needs and wishes. This means they are fully involved in decisions about their care and support which affect them. People choose where and how they spend their time and benefit from maintaining and developing their interests and what matters to them. People are supported to be emotionally resilient and have a strong sense of their own identity and wellbeing. The impact of people's health condition or diagnosis is taken into account when supporting people to identify outcomes which build their aspirations.	People experience care and support at a basic level, focused on tasks and routines which does not treat adults living in the care home as individuals entitled to personalised care. The quality of people's experience is negatively affected because staff do not know the person or use their personal plan to enhance both the care provided and social interactions. There is a lack of recognition of people's interests, culture or past life, including sexuality, spirituality or important relationships with little acknowledgement of the importance of this for each person.

People are enabled to get the most out of life with options to maintain, develop and explore their interests and skills, which may include education and learning, employment and leisure. There are opportunities to connect with family, friends and contribute to the local community in a variety of ways. People with specific communication needs or cognitive impairment are supported to participate in ways which suit them best. People are supported to build and maintain meaningful relationships with others, within and outwith the care home. People are able to choose how they spend their money or receive the right support to manage it.	Opportunities for meaningful activity are sparse and may only include group or indoor activities at set times of the day or week. Choices are limited and people's aspirations are restricted by assumptions of what is safe or possible. People who communicate in different ways are disadvantaged because staff have difficulty understanding and supporting them or lack the resources to respond appropriately. People lack a sense of purpose or direction because the service does not provide enough structure or stimulation to enable this.
People feel safe and staff demonstrate a clear understanding of their responsibilities to protect people from harm, neglect, abuse, bullying and exploitation. Measures are in place to prevent this happening, and staff are confident that if they identify concerns, the open and supportive culture within the care home ensures that they are responded to appropriately. People's right to make choices and take informed personal risk is fully embedded within the culture of the care home. Staff have the skills and understanding to support people to exercise this right, enabling ambitious and aspirational choices.	People may not be, or may not feel safe and staff are unclear of their role in identifying and reporting concerns about the safety and wellbeing of people. Appropriate assessments, supports and referrals may not be made. Harm may be ignored or not identified, for example as a result of assumptions that altercations between people are inevitable. Staff may participate in or accept poor practice without considering the impact on people's emotional wellbeing and dignity. The culture makes it hard to report poor practice which may lead to people being at risk of unsafe care and support.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe staff practice and interactions • Discussion with – people living in the care home, relatives, friends, visitors and staff • Review meeting minutes and action plans for people, relatives and staff • Review how care and support plans are informing care and evidence change • Review the adult protection procedure, training, knowledge and referrals made • Look at how people spend their time and any policies or records which relate to this	The Keys to Life: **http://keystolife.info/ and implementation framework: https://keystolife.info/wp-content/uploads/2019/03/Keys-To-Life-Implementation-Framework.pdf** Autism Strategy for Scotland: **http://www.autismstrategyscotland.org.uk/** Good Communication Standards **https://www.rcslt.org/news/docs/good_comm_standards** Scottish Recovery Network – Peer Support **https://scottishrecovery.net/wp-content/uploads/2011/09/srn_exe_form.pdf** Wellness Recovery Action Plan **http://mentalhealthrecovery.com/** Information on supporting people with complex needs and sight loss **https://www.rnib.org.uk/professionals-social-care-professionals/complex-needs-social-care** Information resources on person-centred practice **http://helensandersonassociates.co.uk/person-centred-practice/** Mental Health Foundation – Recovery Checklist **https://www.mentalhealth.org.uk/** Disability Rights UK – doing sports differently **https://www.disabilityrightsuk.org/doing-sport-differently**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Jenny's Diary – supporting conversations about dementia with people who have a learning disability **http://www.learningdisabilityanddementia.org/jennys-diary.html** Promoting Excellence in dementia care (includes people with a learning disability and dementia) **http://www.sssc.uk.com/workforce-development/supporting-your-development/promoting-excellence-in-dementia-care** See Hear – framework for meeting the needs of people with a sensory impairment **http://hub.careinspectorate.com/media/179158/sg-see-hear-sensory-impairment-strategic-framework.pdf** General standards for neurological care and support 2019 **http://www.healthcareimprovementscotland.org/our_work/long_term_conditions/neurological_health_services/neurological_care_standards.aspx**

Quality indicator 1.3: People's health benefits from their care and support

Key areas include the extent to which people experience:

- care and support based on relevant evidence, guidance, good practice and standards
- the right healthcare from the right person at the right time
- food and drink that meets their needs and wishes.

Quality illustrations	
Very good	**Weak**
People benefit from a comprehensive holistic health assessment, screening and care and support based on good practice and evidence-based guidance. People have as much control as possible over their medication and benefit from a robust medication management system which adheres to good practice guidance. People's medication is regularly reviewed to ensure that their medication meets current health outcomes. People experience a range of opportunities and health education that can promote health and wellbeing. People have control of their own health and wellbeing by using technology and other specialist equipment.	People's care and support may be compromised because health assessments are basic and do not reflect evidence-based practice, or do not involve the appropriate people. The support which people receive and how they spend their time has limited links to health promotion, recovery and/or harm reduction. There is limited access to equipment and technology and its use is often focused on assisting staff rather than on allowing people to have more control over their life.

Where relevant, people benefit from registered nurses leading on the delivery of high quality nursing care. People benefit from regular healthcare assessments, access to community healthcare and treatment from competent trained practitioners, including prevention and early detection interventions. People are well informed about their treatment or intervention because information about treatment options, rehabilitation programmes or interventions is available in a format which is right for them. This helps ensure that people experience treatments or interventions which are safe and effective. People are fully involved in making decisions about their care and support through their personal plans, including long term and life-limiting conditions. People experience a range of opportunities which promote health education, including sexual health.	Access to appropriate healthcare in their local community may be limited. Even where there is access to healthcare professionals, people's healthcare needs are not reliably followed through. This may result in people experiencing reactive or disjointed care and support, which could impact on health outcomes. People may not always receive the right medication or treatment at the right time with the potential to affect health outcomes. The use of 'as required' medication may not be clearly laid out or in line with good practice guidance. Where people's medication needs to be given covertly, the relevant legal powers, consent and processes are not in place. People only access health or sexual health education in response to specific issues, rather than as part of the service's ethos of health promotion.
People are central to the planning, budgeting, shopping, and preparation of food as part of their daily life and these are used as an opportunity to build skills and independence. People can prepare healthy meals, snacks and drinks which reflect their cultural and dietary needs and preferences, including fresh fruit and vegetables. People enjoy their meals in an unhurried, relaxed atmosphere when and where they want to. People benefit from a wide range of aids and have the required support..	People have insufficient opportunities to be involved in purchasing, growing, preparing and serving their own food. Options for meals, snacks and drinks are limited and do not always reflect people's cultural and dietary needs. People often do not enjoy their meals and do not always receive the right support to help them eat the best diet for them. There are limited methods used to help people make choices at mealtimes resulting in others often making the choices for them. Staff may control access to food and drink without professional rationale and as a result people may not be able to eat or drink when they want or need to.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe care and support at mealtimes • Assess tools used for people to identify / monitor health needs • Review how care and support plans are used to promote people's health, including specific plans to support people with for example, epilepsy or behaviour support plans • Discussions with people, staff, relatives/carers • Key areas for adults experiencing life-limiting conditions that must be looked at are skin care, nutrition (including special diets, weight loss, fluid intake), medication, where people are fed using PEG • Speak with other professionals who provide support to the home or individual. Contact and seek views of GP and visiting nurses, mental health officer, dieticians, and any other professionals as appropriate.	National Institute for Clinical Excellence guidance on Medicines Management in Care Homes, 2014 **https://www.nice.org.uk/guidance/sc1** Guidance about medication, personal plans, review, monitoring and record keeping in residential care services **http://hub.careinspectorate.com/media/52042/medication-recording-july-2012-web.pdf** Notifications about controlled drugs: guidance for providers, 2015 **http://www.hub.careinspectorate.com/media/226266/notifications-about-controlled-drugs-guidance-for-providers-v1-.pdf** Mental Welfare Commission good practice guides: Covert Medication **https://www.mwcscot.org.uk/media/140485/covert_medication_finalnov_13.pdf** Alcohol Related Brain Damage **https://www.mwcscot.org.uk/media/438968/arbd_gpg.pdf** Pressure ulcer Prevention and Management standards 2018, Tissue viability toolkit, model policy all available at: **www.pressureulcer.scot** Scottish Commission for Learning Disability Healthy Eating Healthy Living Pack **https://www.scld.org.uk/healthy-eating-healthy-living-pack/** Spotlight on food and fluid / bowel and bladder health – the Hub **http://hub.careinspectorate.com/improvement/spotlight-on-improvement-for-adults-and-older-people/spotlight-on-food-and-fluid/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Mental health supports – do staff know which aspects of their support is covered by compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCTA) and what their responsibilities are, including under the principles of the Act? Where residents are subject to current MHCTA powers, is there a copy of the order and the responsible medical officer's care plan?	Autism Hospital Passport **https://www.autism.org.uk/about/health/hospital-passport.aspx** Falls prevention for people with learning disabilities **https://hub.careinspectorate.com/media/1540/injury-and-fall-prevention-for-people-with-learning-disabilities.pdf** Sexual Health Framework 2015-2020 **https://www.gov.scot/publications/sexual-health-blood-borne-virus-framework-2015-2020-update/#res484414** Accessible health information **http://easyhealth.org.uk/**

Quality indicator 1.4: People are getting the right service for them

Key areas include the extent to which people:

- are fully involved in the professional assessment of their holistic needs
- can choose the care and support they need and want
- experience high quality care and support as result of planning, commissioning and contracting arrangements that work well.

Quality illustrations	
Very good	**Weak**
The care and support people are experiencing is right for them, based on their needs, rights and choices. People are involved in a comprehensive assessment of their needs in a meaningful way and this has informed the care and support they experience. Where relevant, the assessment involves other people, families, friends and professionals to help shape the decision about the suitability of the service for them. People and professionals are involved in reviewing the assessment.	People have limited or no involvement in their assessment and review processes. There may be limited involvement of other relevant people, including professionals, to help shape the decision about the appropriateness of placement. The assessment process does not fully capture people's current needs or take account of their future needs and preferences.
People have been able to choose the care and support they wish to use, based on their assessed needs. People are involved in planned care reviews and evaluations in a meaningful way to determine whether the care and support meets their needs. Where there are identified changes to their needs, appropriate measures are taken to address these	The commissioned service which people are experiencing does not meet their needs, rights or choices. People's choices about their care and support are compromised or undermined by pressure on resources. Decisions about their care and support arrangements are made for people without appropriate legal powers or without taking into account the principles of relevant legislation.

People benefit from strong links between the provider and the health and social care partnership to ensure that current and future care needs and wishes are met and planned for. If the person's needs change so that the current support setting is no longer appropriate, or the service intends to close, there is a co-ordinated and planned approach to look at suitable alternative support. Planning for this involves the person and fully takes account of their wishes and preferences.	People do not always benefit from planned reviews and evaluations of care, involving relevant others, which means that their needs are not being fully met. There may be delays in responding to their changing needs. If someone is living in a care home which doesn't fully meet their needs, there may be a lack of a coordinated and planned approach to look at alternative care and support taking account of their wishes and preferences.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• SOFI 2 observation • Observation of staff practice and interactions • Discussions with people, staff, relatives/carers and other professionals • Review notes and action plans • Care plans • Meeting minutes and action plans people, staff and relatives • Advocacy links and discussion with advocacy in the care home • Policy / procedure for accessing other services • Look at the aims and objectives of the service	Understanding Personal Outcomes, from the Scottish Social Services Council: **http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=39** Supported decision making, from the Mental Welfare Commission **https://www.mwcscot.org.uk/publications/good-practice-guides/**

Key question 2:
How good is our leadership?

This key question has four quality indicators associated with it.

They are:
2.1. Vision and values positively inform practice
2.2. Quality assurance and improvement is led well
2.3. Leaders collaborate to support people
2.4. Staff are led well

Quality indicator 2.1: Vision and values inform practice

Key areas include the extent to which:

- vision, values, aims and objectives are clear and inform practice
- innovation is supported
- leaders lead by example and role model positive behaviour.

Quality illustrations	
Very good	**Weak**
There is a clear vision that is inspiring and promotes equality and inclusion for all. Leaders are aspirational, actively seeking to achieve the best possible outcome for people and this is shaped by people's views and needs. The aims and objectives of the care home inform the care and support provided and how people experience this.	The vision is unclear. It lacks clarity, collective ownership and does not focus sufficiently on improving outcomes. There is no, or limited evidence that equality and inclusion are embedded either within policies, procedures and plans or from observing staff practice. Staff's awareness or knowledge of the vision, values and aims are minimal and do not inform practice.
The culture encourages creative contributions from staff and people living in the care home. Staff are empowered to innovate and provide person-led care and support, fostering a culture of positive risk-taking. Learning from this is shared, including when things go wrong. In the spirit of genuine partnership, all relevant plans, policies and procedures reflect a supportive and inclusive approach. Leaders and staff recognise the importance of an individual's human rights and choices, and embrace the vision, values and aims to support these being met.	Where improvements are needed, there is limited innovative thinking and staff do not feel confident in contributing to or implementing improvement. Staff may not think creatively about how to change practice in order to meet people's needs and wishes and may be unable or unwilling to tailor care and support for individuals.
Collective leadership is evident, with capacity for leadership being built at all levels. Leaders ensure that the culture is supportive, inclusive and respectful and they confidently steer the care home through challenges where necessary. Leaders are visible role models as they guide the strategic direction and the pace of change.	People experiencing the service, their relatives and staff do not have confidence in leaders. Leaders are not visible role models, and not well known to staff, people and relatives. Their leadership may lack energy, visibility and effectiveness.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of practice and interactions • Quality assurance of relevant policies, procedures, records and outcomes • Discussion with people, staff, relatives and other professionals • Meeting minutes and action plans • Examining how people quality assure what they do • Looking at improvement plans, aims and objectives	Scottish Social Services Council – Supervision guidance: **www.stepintoleadership.info/supervision.html** Scottish Social Services Council –Steps into leadership : **www.stepintoleadership.info/**

Quality indicator 2.2: Quality assurance and improvement is led well

Key areas include the extent to which:

- quality assurance, including self evaluation and improvement plans, drive change and improvement where necessary
- leaders are responsive to feedback and use learning to improve
- leaders have the skills and capacity to drive improvement.

Quality illustrations	
Very good	**Weak**
Staff continually evaluate people's experiences to ensure that, as far as possible, adults living in the care home are provided with the right care and support in the right place to meet their needs. People are well-informed regarding any changes implemented, and their views have been heard and taken into account. Leaders empower others to become involved in comprehensive quality assurance systems and activities, including self-evaluation, promoting responsibility and accountability. This leads to the development of an ongoing improvement plan that details the future direction of the care home. This is well managed, with research and good practice documents being used to benchmark measurable outcomes.	There are some systems in place to monitor aspects of service delivery, however there is confusion and a lack of clarity regarding roles and responsibilities. Quality assurance processes, including self-evaluation and improvement plans, are largely ineffective. The approaches taken are not sufficiently detailed to demonstrate the impact of any planned improvement. There is little effective evaluation of people's experiences to ensure that their needs are being met. The lack of individualised care and aspirations to help people get the most out of life risks having a detrimental effect on people's overall wellbeing.

People feel confident giving feedback and raising concerns because they know this is welcomed and responded to in a spirit of partnership. Where things go wrong with a person's care or support or their human rights are not respected, leaders offer a meaningful apology and learn from mistakes. Leaders understand how the duty of candour will impact on their care and support. Leaders use learning from adverse incidents and complaints to improve the quality of care and support. People are supported to understand the standards they should expect from their care and support and are encouraged to be involved in evaluating the quality of the service provided.	Leaders do not use success as a catalyst to implement further improvements. They may fail to motivate staff and others to participate in robust quality assurance processes and systems. The lack of information regarding the rationale and need for improvement may inhibit change. Changes may happen as the result of crisis management rather than through robust quality assurance and self-evaluation. There is a lack of analysis of incidents and limited efforts to learn from these. People are either unclear how to raise concerns or make a complaint, or do not feel supported to do so. Complaints and concerns may not drive meaningful change when they could or should. Where things do go wrong, leaders may be defensive and unwilling to learn from mistakes.
Leaders demonstrate a clear understanding about what needs to improve and what should remain, and they ensure that the needs and wishes of people living in the service are the primary drivers for change. Leaders at all levels have a robust and clear understanding of their role in directing and supporting improvement activities and where to obtain support and guidance. The pace of change reflects the improvements needed.	There is insufficient capacity and skill to support improvement activities effectively and to embed changes in practice. The pace of change may be too slow. Audits of key functions are not in place or gather superficial data.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Discussion with people, staff and relatives • Review minutes of meetings and action plans for people, staff and relatives • Quality assurance and oversight of relevant policies, procedures, records and outcomes – for example, medication, support plans, the environment • Manager's overview of training, supervision, SSSC registration • Look at the improvement plan • Review accident/incident records, audits and outcomes • Look at complaint and concerns records, audits and outcome • Understand how the service gathers feedback and action take, including how this is built into induction and supervision • Analysis / evaluations from participation methods/ activities	The Model for Improvement and associated resources: **hub.careinspectorate.com/improvement** Duty of Candour guidance: **http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=84** National Occupational Standards (NOS) **http://learn.sssc.uk.com/nos/about.html** EFQM excellence model: **https://www.efqm.org/** Learning from adverse events through reporting and review: A national framework for Scotland 2015: **http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx**

Quality indicator 2.3: Leaders collaborate to support people

Key areas include the extent to which:

- leaders understand the key roles of other partners and their responsibilities
- services work in partnership with others to secure the best outcomes for people
- leaders oversee effective transitions for people.

Quality illustrations	
Very good	**Weak**
Leaders seek to overcome barriers to find a way to enable people to gain real control over their care and support. A culture of joint responsibility and decision-making helps create a positive climate. This takes into account each individual's whole life including people's physical, psychological, cultural, social, emotional and spiritual needs. Because leaders have a sound knowledge of the key roles and responsibilities of partner agencies, they quickly identify when to involve them. Partner or multi-agency working is supported by a clear strategy to facilitate working together so that people get the right support from the right organisation when they need it. Leaders are confident in working across boundaries to support people and ensure they experience high quality care and support. Leaders recognise the benefits of sharing ideas and practice, not just within the care home, but further afield too.	Leaders do not ensure that care and support is provided in collaboration with people, their families, and the wider community. There is a lack of understanding of the roles that others from external organisations carry out which may benefit or provide additional support for people. There is a lack of a clear strategy and guidance to inform a collaborative approach. Leaders are not able, knowledgeable or confident at accessing local pathways for people. They may not work effectively with other organisations, or know how to obtain specialist support when needed.

Where people are supported by more than one organisation, they benefit from organisations working together, sharing information promptly and appropriately, and working to coordinate care and support so that people experience consistency and continuity. Where information is being shared between agencies for specific purposes, consent is sought (except where there is a risk of harm) and privacy and confidentiality are respected.	Leaders may not be confident at learning from other organisations to improve the services they provide, or be willing to work from them. There is a lack of clarity about when communications and contacts should be made to help meet the current needs of people. Leaders may be unclear where to share information. Information about people is not regularly shared when it is appropriate to do so, and where that will lead to improvements in their care and support. Where information is shared, consent may not have been obtained from the person or their representative.
Leaders ensure that moving into the care home is person-centred. People are supported to become a resident in the care home, or move on to another setting if they wish. Leaders ensure that commissioned services are delivered efficiently and effectively. They monitor the success and effectiveness of working with partner providers and other agencies. There are clear processes in place to support people moving on to another care service if they wish or where they no longer require a care home service.	Silo working may impact negatively on people's experiences of health and social care in the care home. Leaders have not put in place robust approaches to support people to become a resident in the care home, or to use other care and support services. As a result, people experience disjointed or rushed moves, leading to uncertainty or distress.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Look at the admission procedure, practice and experience of people • Discussion with people, staff and relatives • Observe practice and interactions • Look at the information sharing policy and practice • Look at arrangements for multi agency working and how these benefit people • Examine links the home has to local resources and how these are used and accessed.	Scottish Social Services Council – Step into leadership **www.stepintoleadership.info** Information Commissioner's Guide to data protection, including GDPR: **https://ico.org.uk/for-organisations/guide-to-data-protection/**

Quality indicator 2.4: Staff are led well

Key areas include the extent to which:

- leaders at all levels make effective decisions about staff and resources
- leaders at all levels empower staff to support people
- leadership is having a positive impact on staff.

Quality illustrations	
Very good	**Weak**
Leaders engage meaningfully with staff, people living in the care home, their families, and the wider community. They take a collaborative approach to planning and delivering care and support. This means that leaders are skilled at identifying and delivering the right resources needed to provide high quality care and support now and in the future. They intervene at the earliest opportunity to ensure that people experience high quality care and support. Where relevant, registered nurses are empowered to play a key role in leading nursing care, including working with other staff and supporting all staff in delivering high quality care. This results in robust systems of care with clear lines of responsibility and professional accountability including clinical governance.	Leaders lack the skills and knowledge to proactively anticipate the type and level of resources needed for people. This has a detrimental impact and fails to prevent difficulties arising and escalating. Leaders do not identify potential barriers which impact on people, which may mean that adults living in the care home have little influence on decisions which relate to their care and support. There is a lack of vision and creativity in identifying services which may meet the unique needs of each person living in the care home.

Leaders model a team approach, acknowledging, encouraging and appreciating the efforts, contributions and expertise of others, while instilling a 'safe-to-challenge' culture. They listen to others and respect different perspectives. They recognise that people are often best placed to identify their own needs and encourage staff to support this approach. Leaders recognise the importance of sharing ideas in a relaxed and supportive environment and work hard to tackle inequalities, encouraging equality of opportunity both among the staff and people living in the service. They use successes to act as a catalyst to implement further improvements in the quality and outcomes for individuals.	Staff are not empowered to help identify solutions for the benefit of people who live in the care home. Communication and direction is lacking and the approach to improvement is not sufficiently detailed. The rationale for change is not always clear to staff, impacting negatively on people's experiences. Leaders may fail to engage or energise staff leading to confusion and a lack of clarity of roles and responsibilities. Equality and inclusion are not embedded within policies, procedures and plans. There is a lack of understanding that staff at all levels have an important role to play in delivering high quality care and support.
Leaders adapt their leadership style to help motivate staff to deliver high quality care and support. A good work-life balance is encouraged at all times, which impacts positively on staff and people who live in the care home.	Opportunities to use initiative, take responsibility and influence change are limited. Staff seldom adopt leadership roles. There is no, or limited evidence that professional learning is linked to organisational priorities. Silo working exists and little attempt is made to address this.

Scrutiny and improvement toolbox

Scrutiny and improvement support actions	Key improvement resources
• Observe practice and interactions • Discussion with people, staff and relatives • Interview manager • Look at the quality assurance policy, procedure, practice and outcomes • Look at staff training records, appraisals, supervision and deployment • Review the improvement plan • Look at minutes of staff and team meetings	Scottish Social Services Council – Step into leadership www.stepintoleadership.info

Key question 3:
How good is our staff team?

This key question has three quality indicators associated with it.

They are:
3.1. Staff have been recruited well
3.2. Staff have the right knowledge, competence and development to support people
3.3. Staffing levels are right and staff work well together

Quality indicator 3.1: Staff have been well recruited

Key areas include the extent to which:

- people benefit from safer recruitment principles being used
- recruitment and induction reflects the needs of people experiencing the care
- induction is tailored to the training needs of the individual staff member and role.

Quality illustrations	
Very good	**Weak**
Staff are recruited in a way which has been informed by all aspects of safer recruitment guidance, including a strong emphasis on values-based recruitment. The process is well organised and documented so that core elements of the procedure are followed consistently. People living in the care home have opportunities and the necessary support to be involved in the process in a meaningful way, which takes their views into account, including in recruitment decisions. Staff do not start work until all pre-employment checks have been concluded and relevant mandatory training has been completed. There is a clear link between the needs of people and the skill and experience of the staff being recruited. There are a range of supports in place to encourage staff retention.	There is insufficient attention to understanding why safer recruitment is important. Key elements of processes may be ignored, for example exploring gaps in employment records or checking that references come from a previous employer. Even where good recruitment policies are written, they may not be implemented thoroughly on every occasion, for example only one reference is obtained and staff start to work alone before their membership of the Protection of Vulnerable Groups scheme has been confirmed. The care home may not fully understand the skill set and experience it needs within its staff team in order to provide high quality care and support for the people they support.

The induction is thorough and has been developed to meet the needs of people in the particular setting. This includes an emphasis on implementing the Health and Social Care Standards as underpinning values for all care and support. There is a clear plan as to what is included and how this will be delivered with sufficient time to ensure that staff can understand all the information and what is expected of them. During the induction period, feedback is sought from people living in the service, family members and colleagues, so that they contribute to the evaluation of staff values, communication and further development needs.	The values and motivation of potential staff may not have been explored as part of the recruitment process and may not inform recruitment decisions. Staff start work before they have sufficient knowledge and skills. They may receive no induction. It may be brief and patchy or there may be too much covered too quickly for it to be effective. They may only have the opportunity for a minimum of shadowing and there is limited structure for additional discussions about their learning needs, either through supervision or a mentor.
The learning needs and styles of individual staff members are taken into account during their induction to help ensure they are well prepared for their role. There is likely to be a range of learning styles, for example, the opportunity for face to face discussion and shadowing of more experienced staff. Staff are clear about their roles and responsibilities, with written information they can refer to and a named member of staff for support. Staff are clear about their conditions of employment and the arrangements for on-going supervision and appraisal. As a result they feel well supported and confident in carrying out their role. There is additional supervision in the first few months to discuss any learning needs or issues.	The induction may be generic, have not been reviewed recently, or may not include effective input about the Health and Social Care Standards. Staff lack confidence in, or have limited understanding of, their role in providing care and support and how they contribute to the work of the organisation because their induction has not adequately prepared them for their job role.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Look at the recruitment policy and procedure • Review the analysis of staff skills required • Look at interview records • Examine how fitness checks are undertaken • Review relevant HR or personnel files • Look at the induction policy, procedure and practice • Look at staff job descriptions and roles • Discussion with people, staff and relatives	Scottish Social Services Council/Care Inspectorate, Safer Recruitment Through Better Recruitment: **http://hub.careinspectorate.com/knowledge/safer-recruitment** The national health and social care workforce plan: part two **https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-2-framework-improving/**

Quality indicator 3.2: Staff have the right knowledge, competence and development to support people

Key areas include the extent to which:

- staff competence and practice supports improving outcomes for people
- staff development supports improving outcomes for people
- staff practice is supported and improved through effective supervision and appraisal.

Quality illustrations	
Very good	**Weak**
Staff competence is regularly assessed to ensure that learning and development supports better outcomes for people. This means that people are being cared for by staff who understand and are sensitive to their needs and wishes because there are a number of learning and support measures in place. There is a clear structure of training for each role within the care home. This includes values, the Health and Social Care Standards and any applicable codes of practice and conduct, as well as specific areas of practice.	Arrangements for assessing ongoing competencies are sporadic and with little encouragement for reflection on how learning needs will be met or how this might improve practice and outcomes for people. Staff may be registered with relevant professional bodies but do not fully understand their responsibilities for continuous professional development or how they can fulfil this. They may lack confidence or support in taking responsibility for their own learning and development.

Learning opportunities are developed to meet the needs of people who live in the care home based on evidence and good practice guidance. This is regularly analysed, with new training planned as people's needs change. People who live in the service are involved in staff development and learning, if this is what they want There are a range of approaches to suit different learning styles and it is evident that all staff have access to training and have their own plan which identifies gaps and how these will be filled. Staff are confident about where to find good practice and advice on how they can support people There is a learning culture embedded within the care home, which includes reflective practice. Staff are comfortable acknowledging their learning needs, as well as challenging poor practice and are confident these will be addressed.	Training is basic and restricted to set topics, often with little mention of values and codes and their importance to inform good care and support. The plan for training is static and may not reflect the needs of people who live in the care home. Training is regarded as an event rather than ongoing learning. There is little access to good practice guidance or opportunity for further discussions to ensure knowledge is consolidated and embedded into practice. There is no effective training analysis for the care home or individual staff. The training plan and records are incomplete or held in a format which does not allow the identification of priorities.
Regular supervision and appraisal are used constructively and staff value them. There are clear records of learning being undertaken and planned which inform what is provided for each member of staff. Staff are aware of their responsibilities for continuous professional development to meet any registration requirements, keep a record of this and have support to achieve this from their employer. The views of people who are supported by staff are used to give staff feedback and are included in supervision and appraisal.	Supervision is irregular, with limited discussion of any issues and no opportunity for reflection on practice, skills, knowledge and what could be improved. Staff may consider that if they have completed all the available training they need nothing else. Where learning needs are identified, the systems for ensuring these are provided are not robust, resulting in gaps in knowledge remaining unfilled.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of staff practice • Discussion with people living in the care home, staff and relatives • Mandatory training for different grades of staff • Staff development plan and outcome, including any training needs analysis • Staff supervision and appraisal • SSSC registration records	Achieving effective supervision – IRISS insight: **https://www.iriss.org.uk/resources/insights/achieving-effective-supervision** Frequently asked questions about SSSC registration: **https://www.sssc.uk.com/knowledgebase/article/KA-01130/en-us** Employer responsibilities–supporting staff with registration: **https://www.sssc.uk.com/registration/employer-responsibilities/** Supporting psychological wellbeing in adults with learning disabilities – an educational framework on psychological interventions **https://www.nes.scot.nhs.uk/media/4148312/LDFramworkPDF.pdf** Framework for continuous learning (SSSC) **http://www.continuouslearningframework.com/**

Quality indicator 3.3: Staffing levels are right and staff work well together

Key areas include the extent to which:

- the skill mix, numbers and deployment of staff meet the needs of people
- there is an effective process for assessing how many staff hours are needed
- staff are flexible and support each other to work as a team to benefit people.

Quality illustrations	
Very good	**Weak**
Because the care home understands the needs and wishes of the people living there, the right number of staff with the right skills are working at all times to meet people's needs. Staff have time to provide care and support with compassion and engage in meaningful conversations and interactions with people. Staff are clear about their roles and are deployed effectively. Staff help each other by being flexible in response to changing situations to ensure care and support is consistent and stable. People can have a say in who provides their care and support.	The numbers of staff are minimal and sometimes insufficient to fully meet the needs of people living in the service. Staff work under pressure and some aspects of care and support may be skipped or missed, affecting outcomes for people. People living in, or visiting the service, perceive staff to be 'rushed'. When matching staff to work with individuals living in the care home, limited importance is placed on staff skills, experience and personality to help people build successful relationships and work well together.
The numbers and skill mix of staff are determined by a process of continuous assessment featuring a range of measures and is linked to quality assurance. This includes taking account of the complexity of people's care and support. Feedback from all parties contributes to this and any dependency assessment takes account of the premises layout where applicable. This includes how best to deploy staff to support keyworking, high quality care and small group living with good continuity of care and support.	The number of staff hours deployed is relatively static, with infrequent reviews and not adjusted to meet changing needs. There may be a dependency assessment but this is not translated into staff hours and no other measures or feedback are used to determine what staff time is required. There may be an over-reliance on agency staff, which leads to people experiencing a lack of consistency and stability in how their care and support is provided, and limits their ability to build a trusting relationship with staff members.

People living in the care home and staff benefit from a warm atmosphere because there are good working relationships. There is effective communication between staff, with opportunities for discussion about their work and how best to improve outcomes for people. Motivated staff and good team working mean that staff spend as much time as possible with people. Staff are confident in building positive interactions and relationships. There is a strong emphasis on the responsibilities of staff who are not involved in providing direct care and support to people, recognising that they play an important role in building a staff team.	The pressure on staff leads them to stick to their designated tasks as there is no capacity to respond to other demands. Despite the best efforts of staff, care and support is basic with little time for speaking with people or supporting them to maintain interests. Communication and team building may suffer due to lack of time and affect staff motivation.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe practice and interaction • Look at the staff rota and deployment • Examine staff roles and duties • Discussion with people who live in the care home, staff and relatives • Look at the care and support plans and assessments of people and how this informs staffing • Interview other relevant professionals • Examine how the manager monitors staffing levels and skill mix, and when adjustments are made	Workforce information: **https://hub.careinspectorate.com/national-policy-and-legislation/policies/workforce/**

Key question 4:
How good is our setting?

This key question has three quality indicators associated with it.

They are:
4.1. People benefit from high quality facilities
4.2. The setting promotes people's independence
4.3. People can be connected and involved in the wider community.

Quality indicator 4.1: People benefit from high quality facilities

Key areas include the extent to which:

- the layout of the setting and quality of fittings meets people's needs
- the setting is comfortable and homely
- the setting is safe and well maintained.

Quality illustrations	
Very good	**Weak**
The setting has been designed or adapted for high quality care and support for example, taking account of good practice guidance such as 'Living in the community' and 'Building Better Care Homes'. People can choose to use private and communal areas and have the right to privacy when they want. People benefit from a setting which is the right size for them, including experiencing small group living where this is possible. They have the equipment which best meets their changing needs and equipment is provided when required. People are actively involved in giving their views about the setting; how well it works for them and what could be improved. They feel they are listened to and can influence changes and upgrades.	The design and layout of the building has a negative impact on the quality of life for the people who live there. The setting does not offer sufficient space or different options where people can spend time. There may be insufficient opportunities for people to experience privacy. Staff do not identify changing needs for equipment or facilities, which means that people may not be able to maintain their independence and get the most out of life. This could include communication technology, reassessing how space is used or items to help people with new experiences or interests.
People benefit from a warm, comfortable, welcoming environment with plenty of fresh air, natural light and sufficient space to meet their needs and wishes. The environment is relaxed, clean, tidy and well looked-after, with no evidence of intrusive noise or smells.	Living space is functional rather than creating a warm, homely environment to meet people's needs and preferences. It may not be clean and there is a lack of attention to standards such as homely touches, decoration and the quality of furniture. Staff areas may encroach on the living space of people who live in the care home.

There are clear planned arrangements for regular monitoring and maintenance of the premises and the equipment to ensure people are safe.	Systems for the ongoing maintenance of the environment and equipment are either not organised or not followed, which may place people at risk. Some equipment may not be fully functioning or break down regularly.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• •Carry out a SOFI 2 observation • Observe practice and interactions • Carry out an environmental walk around and check • Review maintenance records • Discussion with people, staff and relatives	Living in the Community: Housing design for adults with autism **https://www.rca.ac.uk/research-innovation/helen-hamlyn-centre/research-projects/2010-projects/living-community-housing-design-adults-autism/** Care Inspectorate, Building Better Care Homes **http://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf**

Quality indicator 4.2: The setting promotes people's independence

Key areas include the extent to which:

- the setting promotes the independence of people
- people can influence the layout of the setting and decide how to use it
- people can freely choose to spend time outdoors.

Quality illustrations	
Very good	**Weak**
People benefit from a setting which is designed or adapted so that everyone can independently access all parts of the premises they use, including outdoor space. All aspects of the setting promote independence with use of facilities such as kitchens, as well as people having control of their own lighting, heating, ventilation and the security of their bedrooms. In addition, people have their own furniture and are supported to use their own space as they want. People benefit from options to keep connected using technology such as radio, phone, TV and the internet.	The setting does not promote independence and this impacts negatively on people by restricting their movement, or increasing their dependence on staff. This may also curtail people's choices as to where they spend their time. Internal facilities and fittings may also restrict people's choices and comfort in their daily life, such as inappropriate equipment. Options for using technology as people wish are limited.
People are involved in a meaningful way in decisions about the layout of the setting where possible and how the space is used. This encourages people to retain their physical abilities by moving around as much as possible.	People tell us they do not have influence over their living space and it is unclear what opportunities leaders have created for this.
People go outside independently because gardens areas are accessible, well kept and welcoming with options to get involved with gardening or other leisure pursuits. People living on upper floors can access outdoor space as they wish.	Outdoor space is not used to its potential and may not be freely accessible to people.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe the environment, looking at movement for people around building, access to outside and equipment that enables people to be as independent as they want • Observe people experiencing the environment • Carry out an environmental walk around and check • Consider the areas for people to prepare drinks and snacks	Care Inspectorate, Building Better Care Homes http://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf

Quality indicator 4.3: People can be connected and involved in the wider community

Key areas include the extent to which:

- the setting supports people being connected to family and friends.
- the setting has a sense of community and belonging
- people benefit from meaningful links with the local community.

Quality illustrations	
Very good	**Weak**
The location and the culture of the care home supports the inclusion of family and friends which people benefit from. This includes being able to plan for family members, friends or partners to sometimes stay over. There are a variety of ways in which people can stay connected including having easy access to the internet and a telephone. People are routinely and actively supported to make best use of these where appropriate.	The care home lacks or has limited ways of supporting the inclusion of family and friends. The setting or the culture of the care home doesn't allow people to plan for friends and family to sometimes stay over. People's opportunities to stay connected with their family and friends are limited. While there may be access to telephone and the internet, people are not routinely or actively supported to use these, or cannot do so in private.
The design of the setting contributes to people developing relationships, with space to spend time in small groups as well as join larger functions. Leaders try to support people to keep a pet, but balance this with the needs of other people too.	There is limited flexible space which means that people lack choice or privacy to develop friendships or invite friends to visit. There is no or little consideration given to supporting people who wish to keep a pet.

The location of the setting enables people to be active members of the local community. People are routinely supported to access facilities outwith the care home including pubs, clubs and leisure facilities, doctors, clinics, hairdressing, libraries and catering facilities and other places they want to go. There are strong links with the local community that encourage the growth of informal support networks. People benefit from this in a variety of ways including: meeting new people, cross generational relationships, links that support individual interests and introducing different ideas and experiences. People have a sense of belonging and worth through contributing to the wider community.	The culture in the care home is likely to be insular, with limited links to the local community. People may spend all their time in the care home, even when they could, with support, be more involved in their local community. The location of the setting or access to transport links makes it difficult for people to be active members of the local community or to access local amenities. The location of the setting or transport links may enable access to the local community and amenities, however people are not routinely supported where appropriate to access these.

Scrutiny and improvement toolbox

Scrutiny and improvement support actions	Key improvement resources
• Observe practice and interactions • Discussion with people, staff and relatives • Look at information on local resources for use by people • Consider the links and access to the community • Consider how staff support people to keep in touch with important people to them • Review care and support plans • Look at meeting notes and action records from people, staff and relatives.	The keys to life. Scotlands learning disability strategy **https://www.gov.scot/publications/keys-life-improving-quality-life-people-learning-disabilities/** Charter for Involvement **https://arcscotland.org.uk/involvement/charter-for-involvement/**

Key question 5:
How well is our care planned?

This key question has two quality indicators associated with it.

They are:
5.1. Assessment and care planning reflects people's outcomes and wishes
5.2. Carers, friends and family members are encouraged to be involved

Quality indicator 5.1: Assessment and care planning reflects people's outcomes and wishes

Key areas include the extent to which:

- leaders and staff use care and support plans to deliver care and support effectively
- personal plans are reviewed and updated regularly and as people's outcomes change.
- people are involved in directing and leading their own care and support

Quality illustrations	
Very good	**Weak**
People benefit from dynamic, innovative and aspirational care and support planning which consistently informs all aspects of the care and support they experience. People and where relevant, their families, are fully involved in developing their personal plans. Strong leadership, staff competence and meaningful involvement support this happening. Quality assurance and improvement processes ensure this is done well.	Care and support plans are basic or static documents and are not routinely used to inform staff practice and approaches to care and support. They do not accurately reflect the care and support experienced by people who live in the service. People may not know whether they have a personal plan. It may be in a format which is not meaningful to them, or kept in an inaccessible place.
Care and support planning reflects a culture of promoting independence, including the potential for people to reduce the support they receive or a change of care setting.	The standard of care and support planning is inconsistent and is not supported by strong leadership, staff competence and quality assurance processes.
Care and support planning takes account of emergency or unexpected events and identifies how support will continue to be provided and promote stability in people's care and support.	Personal plans focus entirely on people's needs or a deficit-led approach rather than building an enabling approach based on assets or outcomes.

People benefit from care and support plans which are regularly reviewed, evaluated and updated involving relevant professionals (including independent advocacy where appropriate) and take account of good practice and their own individual preferences and wishes. People are helped to live well right to the end of life by making it clear to others what is important to them and their wishes for the future. This includes receiving care in a place of their choice should they become unwell. There are a range of methods used to ensure that people are able to lead and direct the development and review of their care and support plans in a meaningful way.	Multi-disciplinary professional involvement in the support planning and review process may be limited. People may not benefit from professional advice because this is not taken account of in the care planning and review process. Care and support plans do not reflect up to date good practice guidance. Care reviews may not be not carried out in line with legislation.
Where people are not able fully to express their wishes and preferences, individuals who are important to them, or have legal authority, are involved in shaping and directing the care and support plans. Advocacy support has been sought where appropriate. Supporting legal documentation is in place to ensure this is being done in a way which protects and upholds people's rights. Risk assessments and safety plans are used to enable people rather than restrict people's actions or activities.	People may not be involved or have only limited opportunity for involvement in their care and support planning and review process. As a result, the care and support they experience is not consistently in line with their wishes and preferences. Where people are not able fully to express their wishes and preferences, relevant individuals important to them are not involved, or have limited involvement, in the care planning and review process. Supporting legal documentation may not be in place.

People are fully involved in decisions about their current and future health support needs. Their plans and wishes for their life in the future are also fully taken account of. Where appropriate, this involves the use of anticipatory (advanced) care plans.	The culture within the service can be defined as risk averse and directly reduces people's quality of life and experiences as a result of over-protective attitudes and practice. Risk assessments appear punitive or designed to prioritise protecting the organisation rather than keep people safe. Outcomes and aspirations for individuals may be limited by low expectations of people who are involved in assessing and planning their care and support.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation • Observe practice and interaction • Review care and support plans • Examine review minutes and action records • Discussion with people, staff and relatives	Understanding Personal Outcomes, from the Scottish Social Services Council: **http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=39** Talking Points – Joint Improvement Team **https://lx.iriss.org.uk/content/talking-points-personal-outcomes-approach-practical-guide** Outcome-focussed conversations – Joint Improvement Team: **https://lx.iriss.org.uk/sites/default/files/resources/outcomes_focused_conversations.pdf** HIS guidance on anticipatory care planning: **https://ihub.scot/anticipatory-care-planning-toolkit/** Scottish Independent Advocacy Alliance – companion guides **https://www.siaa.org.uk/publications-category/companionguide/** Think local act personal – personalised care and support planning tool **https://www.thinklocalactpersonal.org.uk/Latest/Making-it-Real-how-to-do-personalised-care-and-support/** Mental Welfare Commission guidance:Adults with Incapacity Act in general hospitals and care homes: **https://www.mwcscot.org.uk/publications/good-practice-guides/** Power of attorney guide: **https://www.mwcscot.org.uk/**

Quality indicator 5.2: Carers, friends and family members are encouraged to be involved

Key areas include the extent to which:

- carers, friends and family members are encouraged to be involved and work in partnership with the service
- the views of carers and family members are heard and meaningfully considered.

Quality illustrations	
Very good	**Weak**
There is a supportive and inclusive approach to involve all carers and family members in the delivery of care and support if this is important to the person living in the care home. Where family members have learning or communication difficulties or where English is their second language, they are appropriately supported to be able to express their views fully. Leaders engage meaningfully with people and, with consent, their families. Leaders take a collaborative approach to ensure that they have a thorough understanding of people's views, wishes and expectations. The service understands that the right of family members to be involved in care and decision-making hinges on the consent of the individual and that the wishes and best interests of the person living in the care home must be taken into account. Where there are disagreements, these are responded to sensitively and a shared way forward is sought. Where guardianship or power of attorney are in place, staff are clear which legal powers are relevant and fully involve and consult with the guardian.	Leaders either seldom engage with the families of people, or fail to do so in a meaningful way. There are limited ways for friends or family to be involved and these are often one-way or tokenistic. The views of friends and family are not effectively heard by leaders, resulting in a limited understanding of their views, wishes and expectations. There is little evidence of changes being made to how care and support is provided as a result of this involvement. Where people are the subject of guardianship or powers of attorney, the care home staff don't fully recognise or understand what this means, or where decision-making powers lie. Leaders are not clear when someone lacks capacity to consent, or how to proceed if this is the case. Low expectations or over-protective attitudes from some family members are allowed to define the extent of people's ambition or outcomes.

The care home is led in a way that is strongly influenced by people who live there with the opportunity for family members, friends and carers where appropriate, to be involved in a variety of ways. The views, choices and wishes of people who live in the care home and their family members inform changes in how care and support is provided, even where that challenges previous approaches. If the person living in the care home agrees, families, as well as people who live in the service, have the opportunity to be involved in making recruitment decisions in a meaningful way. The care home staff understand the complexities of family relationships and can provide support to people to try to re-connect with friends or family where these relationships have broken down. Staff understand the value of positive peer support in providing support and improving outcomes for people.	Support for those with learning or communication difficulties or those who have English as a second language is limited. People and their familie have no or limited opportunity to be involved in making recruitment decisions, or their wishes carry little weight in decision-making. Information about people living in the care home is shared with their family members, friends or carers without appropriate consent. Leaders lack knowledge about informed consent. Leaders in the service don't recognise the value of support provided by individuals who are important to the person living in the care home.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observations of practice and interactions • Discussion with people, staff and relatives • Care and support plans • Care plan review and action plan minutes • Meeting minutes and action plans for people, staff and relatives. • Systems for acting on feedback, including complaints	Carers Act: **http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016** Equal Partners in Care: **www.ssks.org.uk/equalpartnersincare** Carers Trust: Triangle of Care **https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health** Scottish Social Services Council Guidance: **http://www.sssc.uk.com/workforce-development/our-current-work/carers** Mental Welfare Commission – guidance for people providing residential care for people subject to the AWI 2000 act. **https://www.mwcscot.org.uk/publications/good-practice-guides/** Mental Welfare Commission – Carers and Confidentiality good practice guide. **https://www.mwcscot.org.uk/publications/good-practice-guides/**

Key question 7: How good is our care and support during the COVID-19 pandemic?

This key question has three quality indicators associated with it.

They are:

7.1 People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

7.2 Infection prevention and control practices support a safe environment for people experiencing care and staff.

7.3 Staffing arrangements are responsive to the changing needs of people experiencing care.

Quality indicator 7.1: People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic

Key areas include the extent to which:

- people's rights are respected, and they are treated with dignity and respect
- people are enabled and supported to stay connected
- people's physical, mental and emotional health is promoted.

Quality illustrations	
Very good	**Weak**
Staff demonstrate the principles of the Health and Social Care Standards in their day-to-day practice. This means that people experience care and support with compassion because there are warm, nurturing and positive relationships between staff and the people they support. Where there are restrictions placed on people's freedom of movement, choice and control to prevent the spread of infection, these are kept to a minimum and undertaken sensitively. Restrictions are clearly documented, linked to risk and implemented with the involvement and consent of relevant individuals. The service keeps restrictions to a minimum and implements them sensitively. Staff recognise the impact that protective equipment (for example masks and visors) may have on communication and relationships with the people they support. They adjust how they communicate and take sensitive steps to minimise any negative impact.	There is a lack of recognition of people's interests, culture or past life, including sexuality, gender identity, spirituality or important relationships, and of the importance of this for each person in relation to the potential impact of COVID-19. People's human rights are compromised because there is a risk-averse approach to restrictions in place to prevent the spread of infection. The restrictions are not reasonable, justifiable, or in line with current good practice. Decisions about care and treatment for people who have a deterioration in their condition are not made on an individual basis or based on the person's best interests. They are not made in consultation with the individual or their families/representatives, taking account of any expressed wishes contained in their anticipatory care plan or ethical practice guidance.

People benefit from creative and innovative ways to stay connected using technology with easy access to the internet and a telephone. People are routinely and actively supported to make best use of these, reducing the potential impact of visiting restrictions. Family members and friends know about visiting arrangements because these are clearly communicated to everyone. This includes people with dementia who are experiencing increased stress and distress and those receiving palliative or end of life care, for whom visiting arrangements are risk-based, proportionate and person-centred. Personal plans reflect people's rights, choices and wishes. They are person-centred and include information on people's preferences for maintaining contact, the supports needed to achieve this with those important to them, and ways they can remain active and engaged. People benefit from regular interactions and engagement from staff, and experience support that promotes independence, dignity, privacy and choice. This includes encouragement and resources to take part in meaningful occupations that validate the person's identity, and providing opportunities to feel included and attached to others, resulting in psychological comfort	Leaders in the service have not co-ordinated and communicated a clear plan for how the service is responding to COVID-19 for staff, people experiencing care, their families and carers. The culture in the service is insular, with limited attempts to establish alternative methods of engaging with families, professionals and other stakeholders. Families and others who are important to people are not kept up to date about the impact of COVID-19 in the service. Despite the best efforts of staff, care and support is basic, with little time for speaking with people or supporting them to maintain interests. The quality of people's experiences is negatively affected because staff do not know them as individuals, or do not use their personal plan to enhance both the care provided and social interactions, including at the end of life. There is a risk-averse approach to the use of any outdoor space, and it may not be freely accessible to people. People's psychological needs are not being met as they lack a sense of purpose or direction because there is not enough additional structure or stimulation when they cannot pursue their normal routines and daily activities.

People can choose well-presented, healthy meals, snacks and drinks that reflect their cultural and dietary needs, including fresh fruit and vegetables. There is a system in place to ensure regular access to fluids and nutrition, especially for people who need support to eat and drink. Records are maintained where required. People feel safe, and staff demonstrate a clear understanding of their responsibilities to protect people from harm, including the risk of infection. Measures are in place to prevent harm, and staff are confident that if they identify concerns or improvements, the open and supportive culture within the service ensures that they are responded to appropriately. Leaders in the service understand the potential challenges presented by COVID-19. They work in partnership with GPs, pharmacists and other health professionals to ensure they have timely access to palliative and anticipatory medications to help alleviate symptoms and reduce suffering. People are encouraged to move regularly and remain as active as they can be, including using outdoor space where possible.	People's choice of meals, snacks and drinks is limited and does not always reflect their cultural and dietary needs. People may not get enough to eat or drink, and the necessary support is not always available to help them with this. People may not be or may not feel safe. Staff are not clear about their role in identifying and reporting concerns about people's safety and wellbeing. People may not always receive the right medication or treatment at the right time, with the potential to negatively affect their health. Repurposing of medication is used inappropriately in place of good medication management systems. People's health and wellbeing may be compromised because processes are not in place to support effective communication about changes or deterioration in their condition. Staff lack understanding about the potential for atypical presentation of COVID-19, particularly in people who are older or frail, and they do not escalate concerns, seeking clinical advice as necessary.

People have an anticipatory care plan (ACP) in place that reflects their wishes and where appropriate, those of their representatives. Staff are familiar with people's preferences for palliative and end of life care. People are supported to be emotionally resilient during the pandemic because staff acknowledge the potential impact of COVID-19 and use imaginative and innovative methods to minimise this. This includes supporting people who are experiencing stress and distress in response to the changes in their environment, routines and exacerbated by media coverage.	Decisions in relation to end of life care or DNACPR are not made as part of a person-centred assessment. The views of the person and their family or any proxy decision maker such as a welfare attorney or guardian are not sought. As a result, there is limited opportunity to consider the risks and benefits of any treatment or intervention for an individual. Personal plans are basic or static documents and are not routinely used to inform staff practice and approaches to care and support during this challenging time.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of staff practice and interactions. • Discussion with: - people who use the service - staff - relatives and carers - other professionals. • Personal plans and relevant documentation. • Policy or procedure for accessing other services. • Observation of the setting, inside and out.	Anticipatory care planning for COVID-19: **https://ihub.scot/acp-covid-19** Coronavirus (COVID-19) ethical advice and support framework: **https://www.gov.scot/publications/coronavirus-covid-19-ethical-advice-and-support-framework/** Dementia and COVID-19 learning bytes: **https://learn.nes.nhs.scot/30500/coronavirus-covid-19/practice-in-the-community-setting/mental-health-dementia-and-learning-disabilities** Healthcare communication support tool: **https://hub.careinspectorate.com/media/3532/communications-tool-for-care-homes.pdf** Mental Welfare Commission. COVID-19 FAQ for practitioners – advice notes: **https://www.mwcscot.org.uk/sites/default/files/2020-05/Covid-19%20advice%20note%20v9%2027%20May%202020.pdf** Palliative care toolkit: **https://www.gov.scot/publications/coronavirus-covid-19-palliative-care-toolkit/** Guide for repurposing prescription only medications in care homes: **https://www.careinspectorate.com/images/documents/coronavirus/Guidance_for_repurposing_medicines_May_2020.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Dementia care during the COVID-19 pandemic: https://www.careinspectorate.com/images/documents/5686/Dementia%20care%20during%20COVID%2019%20pandemic%20-%20final3.pdf?utm_medium=email&utm_source=govdelivery Communication for people with sensory loss during the COVID-19 pandemic: advice for health and social care staff: https://www.pmhn.scot.nhs.uk/wp-content/uploads/2020/04/COVID-19-Communication-for-people-with-Sensory-Loss.pdf Supporting people to keep in touch: https://www.careinspectorate.com/images/Supporting_people_to_keep_in_touch_when_care_homes_are_not_accepting_visitors.pdf Information on 'Near Me' video consulting: https://www.careinspectorate.com/index.php/coronavirus-professionals/near-me Recognising deterioration and supporting people with acute care needs during COVID-19: https://learn.sssc.uk.com/coronavirus/acutecare/

Quality indicator 7.2: Infection prevention and control practices support a safe environment for people experiencing care and staff

Key areas include the extent to which:

- people are protected as staff take all necessary precautions to prevent the spread of infection.

Quality illustrations	
Very good	**Weak**
Staff carrying out housekeeping and cleaning in the service are familiar with required environmental and equipment decontamination processes specific to the COVID-19 pandemic. They are trained in these processes and wear the appropriate personal protective equipment (PPE). They adopt systematic measures to minimise cross infection between different areas of the environment. Leaders carry out regular observations and audits of staff, and staff support each other to ensure that everyone maintains good practice in relation to PPE and infection prevention and control. This includes the safe management of linens, uniforms and waste. There are clear signs directing people to handwashing facilities (and reminders of the recommended technique) that reflect the needs of people using the service, for example accessible pictorial or written cues.	Staff working in the service are not familiar with, or do not follow, up-to-date guidance on infection prevention and control from Health Protection Scotland, Public Health Scotland and the Scottish Government. People are not protected from the spread of infection because cleaning schedules and regimes are not based on good practice guidance or carried out when needed. This may be because there are not enough domestic staff, or because staff have not had the necessary support to devise an effective schedule. Staff show limited understanding of when and how they should use PPE and other infection prevention and control methods (such as handwashing and social distancing). This is because training has been insufficient to enable staff to feel confident about the correct infection control measures.

All staff are able to recognise and respond to suspected or confirmed cases of COVID-19 including following local reporting procedures and contacting local health protection teams. Staff are proactive in recognising and responding to challenges people may have in following guidance on social distancing and infection prevention and control, including those with reduced capacity, dementia, sensory loss and physical and learning disabilities.	Managers do not ensure appropriate actions are taken in response to an incident or outbreak or follow up on actions identified. Sufficient attention is not paid to the difficulties people may have in recognising when and how they should follow infection control and social distancing guidance. This may lead to people not receiving the support they require and putting themselves and others at risk. Staff do not have ready access to the appropriate PPE, either due to poor planning or storage of supplies. People are not supported to understand and make decisions about testing and attempts to seek informed consent from individuals or their representatives are not made.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of staff practice and interactions. • Discussion with: - people who use the service - staff - other professionals. • Cleaning matrix and schedules. • Policies and procedures. • Inspection of the environment and equipment. • Availability of PPE at key points (including alcohol-based hand rub). • Availability of appropriate cleaning materials.	World Health Organization 4 moments – your moments for hand hygiene in residential care: **http://www.nipcm.hps.scot.nhs.uk/media/1444/who-4-moments-residential-care.pdf** COVID-19 information and guidance for care homes and COVID-19 incident or outbreak tool: **https://www.hps.scot.nhs.uk/web-resources-container/covid-19-information-and-guidance-for-care-home-settings/** National infection prevention and control manual: **http://www.nipcm.hps.scot.nhs.uk/**

Quality indicator 7.3: Staffing arrangements are responsive to the changing needs of people experiencing care

Key areas include the extent to which:

- staffing arrangements are right and are responsive and flexible
- staff are well supported and confident
- staff knowledge and skills improve outcomes for people.

Quality illustrations	
Very good	**Weak**
The right number of staff with the right skills are working at all times to meet people's needs because providers and leaders in the care home understand the needs and wishes of the people living there. Staff have time to provide care and support with compassion, and engage in meaningful conversations and interactions with people. Staffing arrangements are determined by a process of continuous assessment that includes consideration of the number of people being supported in their rooms, requiring one-to-one support, or additional support to maintain good hygiene and infection control practices. Staff are clear about their roles and are deployed effectively. Staff help each other by being flexible in response to changing situations to ensure care and support is consistent and stable.	Staffing arrangements are relatively static, with infrequent reviews and are not adjusted to meet people's changing needs. No measures or feedback are used to determine what staff numbers are required. The service does not have a staffing contingency plan in the event that staff are absent as a result of illness, self-isolation or exclusion following a positive COVID-19 PCR test. The numbers of staff are minimal and sometimes insufficient to fully meet people's needs. Staff work under pressure, and some aspects of care and support may be skipped or missed, affecting outcomes for people. There may be an over-reliance on agency staff, which leads to people experiencing a lack of consistency in how their care and support is provided. There are no protocols in place about the use of agency, sessional or bank staff, which are designed to help prevent transmission of COVID-19.

Staff benefit from personal and professional wellbeing support that includes debriefing on the management of difficult situations, personal safety, assessment of workload and bereavement support. There is supportive and visible leadership that enables them to voice their concerns, share ideas and explore ways to promote resilience.	Staff feel fearful about the risks associated with COVID-19 because they lack confidence in the leadership of the service or the protective measures that have been introduced, or because there is poor support and communication. The pressure on staff leads them to stick to their designated tasks because there is no capacity to respond to other demands.
Staff who are not involved in providing direct care and support to people understand how they can contribute to the maintenance of good hygiene, infection control practices and keeping people safe. Staff are supported to keep up to date with current and changing practice, with easy access to a range of good practice guidance relating to supporting people during the COVID-19 pandemic, including Scottish Government and Health Protection Scotland guidance. People are confident that staff have the necessary skills and competence to support them during the pandemic. This includes specific training on COVID-19, the correct use of personal protective equipment (PPE) and infection prevention and control. Observations of staff practice are regularly undertaken to assess learning and competence. Outcomes from this are discussed through team discussions, reflective accounts or supervision. Informal support within the staff team, particularly in relation to infection control measures, is welcome and valued. People can have confidence in their support because any redeployed, temporary or new staff have ready access to the right information about the service and the individual's specific needs and outcomes.	Training does not reflect the changing needs of people being supported in the service during the COVID-19 pandemic. There is limited access to good practice guidance or opportunity for further discussions to ensure that knowledge is consolidated and embedded into practice. There is no effective training analysis for the service or individual staff. The training plan and records are incomplete or held in a format that does not allow the identification of priorities. Staff feel anxious and defensive about making mistakes because there is a critical and punitive culture in the service that has been exacerbated by the unfamiliar protective restrictions introduced in response to the COVID-19 pandemic. Leaders do not engage with the supportive functions available to them and do not make the required notifications to relevant bodies.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of staff practice and interactions. • Discussion with: - people who use the service - staff. • Staff training. • Records of support, supervision and learning and development activities. • Management/senior presence (in person and on-call system). • Evaluation of assessment of staffing arrangements, rotas and staff contingency plan.	COVID-19 contact tracing: **https://www.hps.scot.nhs.uk/web-resources-container/covid-19-contact-tracing-in-complex-settings-health-protection-team-guidance/** COVID-19 clinical and practice guidance for adult care homes: **https://www.gov.scot/publications/coronavirus-covid-19-clinical-and-practice-guidance-for-adult-care-homes/** National Wellbeing Hub for staff: **https://www.promis.scot** Care Inspectorate notification guidance: **https://www.careinspectorate.com/images/documents/coronavirus/Records_that_all_registered_care_services_except_childminding_must_keep_and_guidance_on_notification_reporting_V7.pdf** SSSC staff guidance, wellbeing and learning resources: **https://www.sssc.uk.com/covid-19/** COVID-19 learning materials for health and social care staff: **https://learn.nes.nhs.scot/27993/coronavirus-covid-19**

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