Bankfoot House
Care Home Service

Beechgrove
Moffat
DG10 9RS

Telephone: 01683220073

Type of inspection:
Unannounced

Completed on:
17 April 2026

Service provided by:
Bankfoot House (Moffat) Ltd

Service provider number:
SP2003002525

Service no:
CS2003010779

About the service

Bankfoot House is a care home service registered to provide care to a maximum of 25 older people. Inclusive in this number is a maximum of three places for adults aged 50 years and above. The provider is Bankfoot House (Moffat) Ltd. The service is located in the town of Moffat in Dumfries and Galloway, with easy access to local amenities.

Accommodation is provided over two floors; most bedrooms have ensuite facilities. Each floor has shared bathing/shower rooms. A lift provides access to the upper floor. There are communal areas within the building and access to gardens. Parking is available at the front of the building.
At the time of the inspection there were 24 people living in the care home.

About the inspection

This was an unannounced inspection which took place on 14-16 April 2026 between the hours of 07:45 and 22:00. This inspection was carried out by one inspector from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered since the last inspection.

To inform our evaluation we:

- Spoke/spent time with 12 people using the service and five of their family members.
- Reviewed five completed questionnaires (received from three family members and two staff members).
- Spoke with 17 staff and the management team.
- Observed practice and daily life.
- Reviewed documents.
- Spoke with three visiting professionals.

Key messages

• People experienced warm, caring support from staff who knew them well.
• Families and external professionals expressed they felt people supported were safe and well cared for.
• Activities and daily interactions contributed positively to people's wellbeing.
• Safe medication systems and processes were in place, but required development of as required medication (PRN) protocols, to strengthen these systems further.
• Some personal plans and risk assessments were not detailed or up to date, creating inconsistency for people supported.
• Quality assurance processes and manager's oversight need to be strengthened to support sustained improvement.
• Two requirements made at the previous inspection were not met and have been extended.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	3 - Adequate
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We evaluated this key question as good, where several important strengths supported positive outcomes for people and clearly outweighed areas for improvement.

People experienced warm, compassionate care from a staff team who knew them well. This contributed to people feeling safe, respected, and valued. People told us staff were "kind", "want to please me", and understood their preferences. Families also expressed confidence in the care provided, describing staff as "helpful", "really good at listening" and responsive when concerns were raised.

External professionals confirmed staff were proactive in seeking advice and acted on guidance to support people's health needs. This ensured people benefitted from regular healthcare assessment and intervention from healthcare professionals, at the right time.

People benefited from a varied and meaningful programme of activities. We observed group sessions, including bingo, which were adapted skilfully to include people with different abilities. People were animated and engaged, and several enjoyed sharing memories during a Moffat Monopoly activity. Feedback provided positively reflected a recent ABBA night and planned race night, further demonstrating a commitment to meaningful engagement.

There were good links with the local community, including intergenerational work with a nursery. Planned outings were displayed, and staff ensured people had choice and support, should they wish to participate in outings. A dementia friendly outdoor space provided a safe and accessible area for fresh air and activity, with further improvements planned for this space.

There was a pleasant and welcoming atmosphere within the care home. Communal areas were often quiet. Some people observed to spend increased time in their rooms. Staff were continuing to balance increased 1:1 engagement for people supported, whilst respecting people's personal choices.

People chose where to have their meals and mealtimes were relaxed. People told us the food was good, and we saw appetising meals being served. Alternatives were offered when needed, and the catering staff sought people's feedback daily. This ensured the menu offered variety and reflected people's likes and dislikes. Snacks and drinks were available throughout the day, and diets, including vegetarian options, were catered for providing people with choice.

Catering staff were familiar with people's dietary needs and in preparing modified diets. We discussed use of global framework for standardising food and drink thickness (IDDSI) terminology and preparation of modified diets in line with IDDSI. We discussed with the manager the importance of kitchen staff having clear, accessible information about special diets, fortification, and thickened fluids (See area for improvement 1).

Stress and distress management across the home was variable. Some staff discussed and demonstrated skilled ways in which to support people experiencing stress and distress. However, other staff discussed feeling less confident in supporting stress and distress. There was a positive focus in ensuring all staff access external stress and distress training and this is ongoing. A consistent approach, supported by strong leadership, will help ensure staff receive predictable and reassuring guidance in supporting people's wellbeing.

Medication practice and management was safe and well governed. We observed person-centred practice and improved recording of use of as required medication. However, as required medication (PRN) protocols were not in place to guide staff on when and how these should be used. (See area for improvement 2).

People's finances were managed safely, ensuring people had access to funds for personal items. There was effective oversight in place to support people's finances in line with best practice. The manager was proactively exploring developments for future arrangements to make processes for family members to support their loved ones finances increasingly streamlined.

Overall, people experienced positive health and wellbeing outcomes because of the strengths identified.

Areas for improvement

1. To support people's eating and drinking needs fully catering staff should have accessible, updated guidance around people's nutritional needs. This should include but is not limited to guidance on modified diets, dietary preferences, allergens and those who require enhance food and fluid monitoring.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS),which state: 'My care and support meets my needs and is right for me' (HSCS 1.19) and 'My meals and snacks meet my cultural and dietary needs, beliefs and preferences' (HSCS 1.37).

2. To support people's health and wellbeing and the effectiveness of any support they receive, the provider should improve the documentation of 'as required' medication. This should include, but is not limited to, ensuring that the reason for the administration of the medication, signs and symptoms this may cause and the effectiveness of the medication is documented in sufficient detail.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that: 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses. Leadership demonstrated commitment to improvement, but further work was needed to embed effective quality assurance and responsiveness.

Managers were visible within the service, and staff told us they felt leaders cared about them and listened to their views. However, staff also described occasions where leaders were not as responsive or proactive as they needed to be. This limited the pace of improvement and meant that some issues were not addressed as quickly as they could have been.

The management board was very active and there was a regular presence of board members within the care home. Staff spoke positively about this visibility and accessibility to the management board. Board meetings which included the registered manager took place on a regular basis.

Team meetings took place, but minutes showed these were often process driven, with limited evidence of reflective practice, wellbeing discussions, or learning and development. Some whole staff meetings had been cancelled, reducing opportunities for staff to come together, share learning, and contribute to improvement.

This meant the service was not consistently supporting a culture of reflection, self-evaluation and continuous development.

Supervision had recently improved in regularity, and staff spoke positively about support from their supervisor. However, supervision records did not always evidence meaningful discussion about practice, development needs, or follow up actions. This limited leaders' ability to monitor staff competence and support professional growth.

Resident meetings had increased in frequency, and the service was beginning to use feedback from the 'Resident of the Day' process. However, actions taken were not consistently documented, and it was difficult to see how people's views influenced change. While we saw positive examples of individual outcomes being met, this was not yet consistent across the service. Plans shared by the service to further develop "You said, we did" and resident of the day processes were positive and should help make improvements undertaken more visible to people and families.

Quality assurance processes required further development. We could see a range of audits were taking place, regularly but they were not yet driving improvement effectively, and actions did not consistently link to the service improvement plan. This meant the service could not clearly demonstrate how identified issues were being addressed or how progress was being monitored.

Whilst there was internal oversight of accident and incidents, follow up actions, consistent reporting to Care Inspectorate and analysis required improvement. This limited leaders' ability to identify patterns and reduce risk. Therefore the two previous requirements made at the last inspection are not met at this time and will be extended. (See "What the service has done since the last inspection" section of the report).

The service had recorded internal management of complaints and people and families were clear regarding how they could raise any concerns. The service had developed a complaints, compliments, and comments log but this had not been completed. This reduced oversight of concerns, limited opportunities for learning, and meant positive feedback was also not being captured to support staff morale. Establishing this system would help leaders identify trends, celebrate good practice, and respond more effectively to issues raised.

The service had an improvement plan in place, that was regularly updated, but it did not fully align with audit findings or areas of development. This reduced its effectiveness as a tool for driving and monitoring improvement.

Overall, while there were some strengths in leadership visibility and some recent developments in quality assurance, gaps in quality assurance, self-evaluation and improvement planning limited the service's ability to deliver consistent and sustained improvement. Addressing these areas will help strengthen leadership, ensuring consistent outcomes for people supported.

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

We evaluated this key question as adequate, where strengths just outweighed weaknesses.

All people had electronic personal plans, and staff were confident in using the electronic recording system. A significant amount of work had been undertaken to improve consistency, and personal plans were being reviewed more regularly, with monthly updates evident. This helped ensure that people's needs and preferences were kept up to date. However, several assessments and care plans were overdue review.

Some information that was no longer relevant, such as outdated dietary modifications, had not been archived. This created a risk of staff relying on inaccurate or conflicting information.

The quality and detail of personal plans varied. Some plans contained clear, person centred information about what mattered to people, including their history, routines, and preferences. Others were brief, with limited detail about what was important to the person or how best to support them. This inconsistency meant that staff did not always have the information they needed to provide care that reflected people's wishes and promoted positive outcomes.

We found examples where inconsistent or unclear information could lead to increased potential risk for example, documentation not being updated to confirm that relevant professionals were involved when required; dietician for people who were at risk of poor nutritional intake. Where information is unclear, personal plans must be reviewed promptly. Where people required increased nutritional oversight, this was not always clearly documented in personal plans. This included people whose weight is being monitored or those on modified diets. Personal plans should clearly reflect the level of monitoring required to support people consistently. (See area for improvement 1)

A resident review tracker was in place and we could now see the majority of 6-month reviews had taken place. Review minutes sampled had been signed off by the manager and we could see evidence of these being coordinated with people family members or representatives.

Risk assessments were in place but did not always demonstrate a consistent level of detail. For example, risk assessments for people experiencing stress and distress often had blank sections where care actions should have been described. This impacted staff understanding of how to support people safely and consistently. We saw evidence of a positive example of collaborative development of a 'traffic light' stress and distress personal plan, with the community mental health team. This detailed strategies staff could use to ensure consistency when supporting a specific individual experiencing stress and distress.

Resident of the Day processes were more embedded, and we saw monthly feedback being gathered from people by staff across all different departments, which was positive. Further responsive developments were planned by the manager to strengthen this approach.

Anticipatory care plans and hospital information were in place for people, which was positive and helped ensure important decisions were recorded in advance for people ensuring their needs are fully met.

Overall, while there were strengths in the use of electronic care planning and some improvements in review processes, inconsistencies in the quality, accuracy, and evaluation of personal plans limited their effectiveness. Addressing these weaknesses will help ensure that personal planning consistently reflects people's needs, wishes, and outcomes.

Areas for improvement

1. To ensure people's nutritional needs are fully met, the provider should improve recording of people's nutritional needs. This should include updating personal plans when external specialists have become involved, recording consistently food and fluid intake and ensuring all related information in personal plans is current for people supported.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

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

Requirements

Requirement 1

By 15 March 2026, the provider must ensure people experiencing care have confidence the service received by them is well led and managed. You must support better outcomes through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes.

This must include, but is not limited to:

(a) Assessment of the service's performance through effective audit;
(b) Develop action plans which include specific and measurable actions designed to lead to continuous improvements;
(c) Detailed timescales for completion/review;
(d) Alignment systems to best practice guidance.

This is to comply with Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulation 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes'. (HSCS 4.19)

This requirement was made on 2 December 2025.

Action taken on previous requirement

We could see evidence of increased assessment of the service's performance through audit. There was an audit schedule in place with delegation and clear responsibilities of allocated senior staff in completion of audits. We could see the manager's oversight of this step in the auditing process had improved.

The development of a new follow up auditing tool had been completed. This did not yet support the development of action plans designed to lead to continuous improvements. We could not see clearly how the outcomes of audits were informing and linking clearly to the service development plan across all areas of the care home.

There is currently limited evaluation or analysis of trends identified via audit or evidence of this influencing development of practice. We could not be assured that quality assurance systems were able to drive sustained improvement.

Therefore, this requirement has not been met and the timescale will be extended to 10 August 2026.

Not met

Requirement 2

By 18 January 2026, the provider must ensure that the Care Inspectorate are notified of all significant events as per Care Inspectorate Notification Guidance.

This is to comply with Regulation 4(1)(b) (Records, notifications and returns) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulation 2011 (SSI 2011/28).

This is to ensure that care and support is consistent with the Health and Social Care Standards which state that:
'I use a service and organisation that are well led and managed', (HSCS 4.23) and
'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected'. (HSCS 4.18)

This requirement was made on 2 December 2025.

Action taken on previous requirement

Whilst we have continued to receive notifications from the service, we could see these did not align with the service's internal accident and incident records, highlighting missed events which were notifiable to the Care Inspectorate.

Documentation for accidents/incidents and other notifiable events did not always accurately reflect the actions taken by the service including, monitoring for people supported, staff debriefing or lessons learned from events.

We discussed with the service current internal incident and accident reporting processes. We could see staff are immediately reporting accidents and incidents effectively to senior staff. However, we could not be assured that further oversight and review of these events by the registered manager was happening within an appropriate timescale.

We therefore could not be assured leaders were confident in what is and is not notifiable to Care Inspectorate.

Therefore, this requirement has not been met and the timescale will be extended to 10 July 2026.

Not met

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The provider should have in place guidance for staff to follow when a person supported experiences an accident, incident or becomes unwell and requires to be 'monitored'.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes'.
(HSCS 3.14)

This area for improvement was made on 6 November 2025.

Action taken since then
We could see there was clear reporting by staff when a person had experienced an accident/incident, become unwell or was required to be 'monitored'. For example, following a fall. However, there was no clear documentation or guidance of how monitoring is to be undertaken by staff. For example, explicit actions to be taken, frequency of observations or duration monitoring is required for. Therefore, we could not be assured that monitoring undertaken for people supported was being documented accurately.

This area for improvement is not met.

Previous area for improvement 2

The registered manager should complete an analysis of falls that occur so learning and improvement can take place to reduce the future risk of falls.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'. (HSCS 1.15); and
'My care and support meets my needs and is right for me'. (HSCS 1.19)

This area for improvement was made on 6 November 2025.

Action taken since then

We could see evidence of some increased oversight by the manager in relation to recording of a monthly falls overview and a falls audit. However, there was a lack of falls analysis specific to individual people supported. This meant the service was less able to establish any patterns for people, reducing risk of future falls.
We could not see clear evidence of falls analysis influencing development of personal plans and risk assessments.

This area for improvement is not met.

Previous area for improvement 3

The provider should improve their oversight of the Scottish Social Services Council (SSSC) requirements and ensure staff are appropriately registered within the required timescales.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes'.
(HSCS 3.14)

This area for improvement was made on 6 November 2025.

Action taken since then

The service had developed an additional check during the recruitment process to support new staff, to register with the Scottish Social Services Council (SSSC) in the required timescale.

We could see there was a monitoring system in place to track staff's professional registration with the SSSC however, this still did not include all staff details to ensure all staff's renewal of their registration was taking place within the appropriate timescales. We could not be assured the manager had consistent oversight of this process and that effective cross-checking of staff registration between the SSSC and internal system was occurring.

The management board had shared plans to reimburse the staff team for their registration fees and as part of this process, planned to implement an additional check to reduce the risk of this in future.

This area for improvement is not met.

Previous area for improvement 4

To support good outcomes for people staff should be trained and have the necessary skills. Competency assessments should be completed to evaluate staff skills and knowledge against legislation and best practice. Competency assessment records should also evidence any areas for improvement and how these will be met.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes'.
(HSCS 3.14).

This area for improvement was made on 6 November 2025.

Action taken since then

Competency assessments are now beginning to take place. We could see all required staff have recently completed a medication competency. Some staff spoke positively about these and aware observations of practice and competencies for other areas of staff practice are planned but have not yet commenced.

We could not see any records for competency assessments or observations of practice.

This area for improvement will not be met.

Previous area for improvement 5

Prior to admission to the home the registered manager or appointed staff member should complete an assessment of people's needs. This is to determine that the service is able to provide the correct level or care and support required.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected'. (HSCS 4.18)

This area for improvement was made on 16 August 2024.

Action taken since then

Since the last inspection there had been new admissions to the service. Attempts were made to visit people prior to admission to the care home and rationale was clearly documented if this had not been possible. In the absence of a visit, there was clear evidence of discussion with the person and/or their family or representative.

There was evidence of assessment from other agencies being used to inform the pre-admission assessment including social work and relevant health professionals. Relevant information was being recorded with increased consistency. The service had not yet developed a standardised template to be used however the information collated was consistent.

This area for improvement is met.

Previous area for improvement 6

To ensure people receive the care and support required to meet their needs, the service provider should review and update information within people's personal plans. This includes reviewing health assessments and updating people's care plans where required.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'. (HSCS 1.15)

This area for improvement was made on 11 May 2022.

Action taken since then

Updates to people's personal plans were now happening with increased regularity. Staff aimed to review care plans monthly, however we found some assessments had not met these timescales and were overdue.

There was some detailed information within plans, however we could see information relating to who people are and what is important to them, alongside information in relation to health monitoring which had still not been completed.

The staff team were continuing to progress this area, however this area for improvement has been in place for almost four years. This is reflected in the evaluation of Key question 5 - 'How well is our care and support planned?' This was discussed with the service and the potential impact to people supported in the future if this is not remedied with increased consistency.

This area for improvement has not been met.

Previous area for improvement 7

People should have the opportunity to review their care and support at least six-monthly, or earlier if required. The provider should coordinate review meetings with people and where appropriate, include family members or their representative.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I am involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change'. (HSCS 1.12)

This area for improvement was made on 11 May 2022.

Action taken since then

Six-month reviews were now happening regularly. These reviews were being coordinated with family members and a six-month review tracker was in place.

This area for improvement is met.

Previous area for improvement 8

To ensure that people's care and support needs are met with a responsive and person-led approach, the manager should ensure that staffing arrangements are safe. This includes, but is not limited to, regular assessment and review of people's care needs, using a multi-angled approach to inform staffing arrangements and implementing robust quality assurance systems, to demonstrate consistency and management oversight.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I am confident that people respond promptly, including when I ask for help'. (HSCS 3.17).

This area for improvement was made on 12 May 2025.

Action taken since then

We were able to see consistent and accurate use of a dependency tool to assess people's care needs. There was evidence of variations being inputted by the manager when there were changes to peoples' needs for example, someone being nursed in bed. We could see the manager is completing this regularly. Families commented they felt staffing had increased.

Staffing rotas reflected the hours highlighted from the dependency assessment. There was current recruitment and onboarding of three new staff members, which was a positive development.

This will support continued safe staffing especially at times when the service had still been experiencing short notice absence, often at pressured times for example, nightshift and weekends. The manager was able to demonstrate increased oversight of this but recognised challenges remain in relation to staffing. Consideration to thinking more flexibly regarding staff scheduling and changes to this was discussed, including possible development of domestic staff scheduling.

This area for improvement is met.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

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

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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