Grandholm Care Home
Care Home Service

Grandholm Drive
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Type of inspection:
Unannounced

Completed on:
5 June 2026

Service provided by:
Holmes Care Group Scotland Ltd

Service provider number:
SP2020013480

Service no:
CS2020379125

About the service

Grandholm Care Home is a home for older people. They are registered to provide support to 79 people over the age of 65 years. This includes a maximum of four places for those 50 years and over.

The home is a three-storey purpose-built home located in a quiet residential area within the city of Aberdeen. All bedrooms have en-suite toilets and shower rooms and there are communal dining and lounge areas on each floor. The home has a small, enclosed garden that can be accessed via the ground floor.

At the time of the inspection 73 people were being supported by the service.

About the inspection

This was an unannounced inspection which took place between 1 and 5 June 2026. The inspection was carried out by three inspectors from the Care Inspectorate.

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

In making our evaluations of the service we:

- spoke with 16 people using the service
- spoke with six family members
- spoke to members of the management team and five staff
- received survey responses from 14 family members, 11 external professionals and 20 staff members
- observed practice and daily life
- reviewed documents.

Key messages

• People said they were happy living in the home and families told us that the staff were friendly and approachable.
• Staff were visible and there were enough staff to care for people.
• During the inspection we found areas of weak performance across key areas which included how the service supported people's wellbeing, personal planning and record keeping. Improvements were required to ensure people's health and wellbeing needs were being met.
• Improvements were also required to quality assurance processes to improve outcomes for people.

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?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	3 - Adequate
How well is our care and support planned?	2 - Weak

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

How well do we support people's wellbeing? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

Feedback from people, families and external professionals about the service was positive. Families and external professionals said staff were "great", "patient" and "approachable". Families told us they were made to feel welcome in the home and that there was an 'open door' policy for visiting. People we spoke to appeared to be happy and comfortable living in the home.

We observed some kind and warm interactions between staff and the people they supported. However, we did observe some interactions which were less positive. For example, staff did not consistently offer choices at mealtimes, and in some cases they put meal protectors on with no explanation or consent. We also observed occasions where staff did not respond promptly when people required support during mealtimes or did not recognise when people required assistance. These examples showed, that whilst care was generally respectful, practice was not always consistent in promoting choice, dignity and timely support.

We found some people's care and support was compromised because the quality and consistency of recordings was poor. For example, we found gaps in records, limited information in daily notes, illegible writing and records indicating equipment had been checked where no equipment was in place. These gaps resulted in a lack of accurate and reliable information to guide care, which had the potential to result in poor outcomes and risks to people. (See requirements made in 'How good is our leadership?' and 'How well is our care and support planned?').

Some people were at risk of poor outcomes following falls due to poor record keeping. For one person we found that decision-making in response to falls was not clearly documented. This meant there was no recorded rationale for a decision not to refer to the falls team, potentially limiting access to specialist advice and support. For another, conflicting information about what happened following an incident meant we could not be assured that appropriate action had been taken to keep the person safe.

We could not be assured that pressure care arrangements were being monitored consistently. This was because some people's repositioning charts were not filled in correctly, and there were also gaps in records. This meant there was limited assurance that people with fragile skin were being repositioned as regularly as they should be to reduce the risk of pressure damage. We also found that airflow mattress settings were not routinely checked or recorded, and found one mattress to be set incorrectly for the person's weight. This also increased the risk of damage to people's skin. (See requirement made in 'How good is our leadership').

There was a varied menu in place, however mealtime experiences were inconsistent. People were not always offered choices and there were missed opportunities to encourage adequate nutritional intake. We also observed that smaller portions were offered on one floor, which may not have met people's individual needs.

We had concerns about some people's nutritional needs not being met. Information to guide staff was unreliable. For example, two people who required fortified diets were not included on the list used by staff, and staff gave conflicting information about when and how food was fortified. During our mealtime observations on the first day of inspection, we did not see any evidence of fortification being added to meals. Record keeping was also poor.

For people at risk of weight loss, daily records lacked detail about what had been offered or eaten, which meant that people's nutritional intake could not be effectively monitored. While fluid balance charts were in place, for those that required this documentation, individual fluid targets had not been recorded. This meant staff could not be confident that people were receiving adequate hydration. As a result, some people were at risk of poor outcomes, including weight loss and dehydration. (See requirement made in 'How well is our care and support planned).

We identified concerns around the accuracy and consistency of oral care assessments and documentation. For example, one person was noted to have red and sore looking gums, with food debris in their mouth which would have caused pain and discomfort. This person's oral care assessment was also found to be inaccurate, which indicated it had not been adequately reviewed prior to being updated. We also identified other people where oral care needs were not consistently assessed or monitored. In addition, an outdated version of a personal care chart was in use which did not include the recording of oral care. This was replaced during the inspection. These concerns demonstrated that oral care was not being managed or recorded consistently, despite it being an important part of people's overall health, comfort and dignity. (See requirement made in 'How well is our care and support planned).

There were systems and processes in place to support the safe management and administration of medication. We found that protocols for 'as required' (PRN) medication were in place and provided clear guidance for staff. As a result, people could be assured that their medication needs were being met in a safe and appropriate way.

The service had continued to develop meaningful engagement since the last inspection, and people spoke positively about the activities on offer. An activity timetable was in place, and the service had purchased some additional resources and equipment to enhance engagement, including robotic animals. We saw these being used to good effect, providing a calming support to people who were distressed. These improvements supported people to participate in meaningful activities and reflected a commitment to improve day to day experiences in the home. We discussed with the management team at the last inspection how further developments, such as sensory areas and activity stations, would be particularly beneficial in one area of the home. This had also been identified by external professionals. We look forward to seeing how this progresses at the next inspection. (See 'What the service has done to meet any areas for improvement we made at or since the last inspection')

Infection prevention and control processes were in place. We found the environment to be clean, tidy and well maintained. Although the external bin area was untidy at the start of the inspection it had been cleaned by the end of the day. These arrangements helped to reduce the risk of infection.

How good is our leadership? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

The management team were visible in the home. In addition to the manager and deputy manager, there were a team of nurses working across each shift. Families told us that the management team was approachable, and they felt able to raise concerns if they had any.

A service improvement plan was in place, and its format had been recently developed. Processes were in place to discuss learning from feedback, incidents and complaints. However, it was not clear how learning was being used to drive improvement. The manager told us that they intended to further develop the plan.

The service should consider how they incorporate self-evaluation as well as people's views into this document so that they can demonstrate that they are responsive to feedback and that they use this to make improvements. We shall review this at the next inspection.

The service had processes in place to monitor aspects of service delivery, including manager walkarounds, audits and a clinical risk register. However, we found limited evidence to demonstrate how information gathered through these processes was being effectively analysed or used to inform improvements. This reduced the service's ability to have a clear and accurate oversight of the quality of care being delivered.

Although clinical governance meetings were taking place, their effectiveness was unclear given the concerns identified in relation to record keeping. This was further demonstrated by the service's own audits failing to identify the issues we found during the inspection.

Quality assurance arrangements did not provide sufficient oversight or evaluation of people's experiences. As a result, inaccuracies and omissions in personal plans and records had not been identified or addressed, increasing the risk of poor outcomes for people. For example, we identified gaps and inconsistencies in call mat recording and use. Two people had call mat charts in place despite not having a call mat, and one record had been completed retrospectively. We also found call mats positioned underneath beds, meaning they would not effectively alert staff if a person mobilised. This increased the risk of people not receiving responsive and timely support after a fall.

These findings demonstrated poor oversight and unreliable quality assurance processes. As a result, risks were not being effectively identified, and this compromised people's safety and wellbeing.

Oversight at all levels of the management team needed to improve. This should include spending more time with people and staff to seek assurance that people receive care in accordance with their assessed needs, that personal plans are updated when people's needs change and that records are accurate and reflective of the care provided. (See requirement 1).

Requirements

1. By 10 August 2026, the provider must ensure that people experience a service that is well led and managed, and which results in better outcomes for people through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes.

To do this, the provider must, at a minimum:

a) Ensure that managers and leaders have effective oversight of people's health and wellbeing needs by continually evaluating their experiences.
b) Ensure quality assurance processes are effective, carried out regularly, and where areas for improvement have been identified, clear action plans are developed which detail the action to be taken and the person responsible for making the improvement.
c) Ensure any actions are reviewed by leaders and are signed off as completed once achieved.
d) Review the effectiveness of actions put in place to ensure these elicit positive outcomes for the health, safety and welfare of people experiencing care.

This is in order to comply with Regulation 4(1)(a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states:

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19)
and
'I use a service and organisation that are well led and managed' (HSCS 4.23).

How good is our staff team? 3 - Adequate

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

The service benefited from having a full staff team in place and there was a team of bank staff who covered shifts when required. People and their families gave positive feedback about staff. They said staff were "friendly", and always had the time to acknowledge them when they visited. Families said there was a "fantastic staff team", that they were "brilliant", and that staff "all worked together as a team".

Managers used a tool, based on people's level of dependency, to inform the number and skill mix of staff needed to meet people's needs. Staff told us they felt supported in their roles and that they had enough time to support people. Staff completed an induction when they started in the service and completed relevant training. Staff said they felt they got the training they needed to do their job well. This contributed positively to day-to-day care and helped maintain continuity and stability for people.

Whilst observations of staff practice were completed in relation to medication administration, no other formal observations of practice or regular supervision had taken place recently. This meant the management team could not fully assure themselves that staff were performing their roles safely, following best practice guidance, or consistently meeting people's needs. The absence of structured observation and supervision limited opportunities to identify gaps in practice, support staff development and address concerns promptly. As a result, there was a risk that poor or inconsistent practice could go unrecognised, impacting on the quality and safety of care experienced by people. The provider should implement a structured approach to staff observation and supervision to strengthen oversight and ensure that support being provided is meeting people's outcomes. (See area for improvement 1).

Areas for improvement

1. The provider should ensure that people are cared for by a well supported staff team. To do this the provider should ensure that staff have regular support and supervision, which is recorded and appropriate to their role. This should include observations of practice and opportunities for staff to reflect on skills, knowledge and learning.

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).

How well is our care and support planned? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

Most people's personal plans had been recently reviewed and audited. However, we identified inconsistencies in some people's plans, and record keeping was of a poor standard. For example, we found information about blood monitoring for diabetes differed across three different documents for one person. While personal plans were outcome focussed, daily records were mostly task orientated and lacked meaningful evaluation. This meant people's personal plans and documentation did not always accurately reflect the care and support experienced, reducing assurance that people's needs were being consistently met. (See requirement 1).

Most reviews were up to date. However, some review documentation lacked detail, and minutes of review meetings did not always demonstrate how people's outcomes were being met. As a result, there were missed opportunities to evidence how the service had improved outcomes for people and how the service was working effectively with external professionals.

Some members of the management team had recently completed care plan training. However, audit training to support the evaluation of care plans had not yet been arranged. We shall review this at the next inspection.

A personal plan and review tracker was in place which provided an overview of when reviews and audits had been completed. However, there was limited evidence of effective management oversight, as reviews and audits had not been monitored by senior staff. In addition, it was unclear whether actions identified through these reviews and audits had been followed up and completed.

Supporting documentation was in place where legal powers applied. This meant staff were aware who was responsible for decisions, helping to protect people's rights. We highlighted a couple of areas that required attention with the manager during the inspection and were confident that they would follow this up with the relevant people.

Requirements

1. By 10 August 2026, the provider must ensure that people experience responsive care and support in a manner which maintains the dignity, health and wellbeing of people.

To do this, the provider must, at a minimum:

a) Ensure people receive personal care, oral care, nail care in accordance with their needs, wishes and preferences.
b) Ensure that where risks associated with weight loss are identified, there are clear plans in place and that all staff are aware of and follow these plans.
c) Ensure staff understand people's needs and carry out care accordingly.
d) Ensure people's health care recording charts and assessments are accurate, regularly reviewed and focused on people's outcomes.

e) Ensure where concerns or changes have been noted in a person's condition or needs, that actions are taken to provide responsive care; this includes following advice and guidance from health care professionals and that this is clearly documented.

This is in order to comply with Regulation 4(1)(a), Regulation 5(2)b(ii), Regulation 5(2)(b)(iii), and Regulation 5(c) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 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:

'My personal 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).

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

Requirements

Requirement 1

The requirement was a result of a complaint.

By 31 October 2025, the provider must demonstrate that people benefit from a culture of continuous improvement, supported by robust and transparent quality-assurance processes.

a) Ensure the implementation of a service improvement plan with clear performance indicators. Use it as a dynamic tool to promote measurable improvements in medication management, care planning, and end-of-life care. It should support anticipatory planning that aligns with individual wishes, clinical needs, and family involvement, all while guaranteeing dignity, comfort, and continuity of care.
b) Implement structured audits across key domains, including medication management; care planning; palliative and end-of-life plans; staff training and competence.
c) Strengthen oversight of staff practice through daily leader-led walkarounds and monitoring, with a clear focus on people's experiences, outcomes and the accuracy of information exchanged between shifts.
d) Deliver tailored training programmes that empower managers and staff to take ownership of clinical oversight and care documentation, fostering confidence, accountability, and continuous improvement in practice.
e) Establish a formal mechanism to record, share and embed lessons learned from complaints, incidents and audits, and to track the impact of these improvements in reducing recurrence.

This is in order to comply with:

Health and Social Care Standard 4.19: I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.

Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care)

This requirement was made on 19 June 2025.

Action taken on previous requirement

There was an updated improvement plan in place. Structured audits had been implemented across key areas, such as medication management, care planning and training. However, we had concerns that audits had not been effective at identifying the concerns that we identified during the inspection. In relation to care plan audits it was not clear on some of the paperwork that we sampled who was responsible for actions that had been identified, where these were being tracked or whether they had been completed.

Some additional training had been arranged for staff which included care plan training and meaningful engagement.

Most people's reviews were up to date, and a tracker document was in place which provided some oversight to the management team.

Whilst medication observations were completed for nursing and senior staff there were no other formal observations of practice completed for staff, which meant there was not effective oversight of day-to-day practice or assurance that staff were consistently working in line with expected standards. We also found that formal staff supervision meetings had not taken place this year, which further limited opportunities to review performance, provide support and identify training and development opportunities. (See 'How good is our staff team?').

Some systems were in place to monitor the quality of care provided, ensure staff were up to date and to discuss lessons learned from incidents and complaints. However, given the areas we identified during the inspection we were not assured that these were impacting on improvements in the service.

Some parts of the requirement have been met and a new requirement has been made to address any outstanding issues. (see 'How good is our leadership?')

Met - outwith timescales

Requirement 2

The requirement was a result of a complaint.

By 31st October 2025, the provider must ensure that all care and support documentation is accurate, up to date and reflects people's current needs, preferences, and legal rights. This is to ensure that care is safe, person-centred, and responsive to change.

To do this, the provider must, at a minimum:

a) Regularly review and evaluate personal plans, particularly following any changes in people's health or wellbeing, to ensure they remain accurate and relevant.
b) Improve the quality and consistency of daily recordings, including repositioning charts, oral care, nutrition, clinical recordings, continence care, and medication administration, ensuring they are complete, accurate and reflective of the care provided.
c) Ensure that future care planning, including end-of-life support, is developed in partnership with individuals, families and professionals and clearly records people's wishes about treatment and preferred place of care.
d) Ensure that all documentation relating to legal authority and capacity is complete, accessible and used to inform care planning and decision-making.
e) Ensure that risk assessments are completed promptly when people begin using the service, or when their needs change, and that these are regularly reviewed and used to inform safe and appropriate care planning.

This is in order to comply with:

Health and Social Care Standard 1.23: My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.

Regulation 5(2)(c) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care)

This requirement was made on 19 June 2025.

Action taken on previous requirement

Whilst the service had audited and reviewed most people's personal plans and introduced processes to monitor people's care and support, these had not identified the areas that we found during the inspection. This meant we could not be assured that people's plans were accurate and there was the potential that this could lead to poor outcomes and risks for people. We also found the quality of daily recordings to be poor and not reflective of the care required or provided.

Future care planning arrangements were in place. Each person had an anticipatory care plan in place and end of life plans were developed when required. Documentation relating to legal authority and capacity was also in place. This meant people's future wishes and legal rights were considered.

Some parts of the requirement have been met and a new requirement has been made to address any outstanding issues. (See 'How well is our care and support planned?').

Met - outwith timescales

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

To promote positive outcomes for people, the provider should ensure that people have safe, independent access to outdoor spaces and that they are supported to engage with the wider community.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential' (HSCS 1.6)
and
'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors' (HSCS 1.25).

This area for improvement was made on 27 November 2025.

Action taken since then

The service had continued to make progress in improving opportunities for meaningful activity and engagement. Activity coordinators continued to develop a program of activities in consultation with people living in the home. This had enhanced and improved opportunities for people.

Improvements had also been made to provide safe access to outdoor spaces and activities were also taking place in the wider community, for example people were attending local events such as "boogie in the bar" at the local community centre.

Work had continued to develop the garden area, and another small garden area had been cleared so that it could also be used. We suggested how adding a gate from the main garden area would improve access to this additional space.

People we spoke to said activities had improved overall. Whilst progress has resulted in improved outcomes there was still scope to ensure this was consistent across all areas of the home. (See 'How well do we support people's wellbeing?').

This area for improvement has been 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?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

How well is our care and support planned?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak

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