Care service inspection report

Cumbernauld Care Home

Care Home Service Adults

Abbotsford Road
Greenfaulds
Cumbernauld
Glasgow
G67 4BW
Telephone: 01236 739979

Inspected by: Beth Lynagh

Lorraine McIntyre

Type of inspection: Unannounced

Inspection completed on: 10 September 2012

Contents

Service provided by:

Tamaris (RAM) Limited, a member of the Four Seasons Health Care Group

Service provider number:

SP2007009152

Care service number:

CS2003010563

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Summary

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change after this inspection following other regulatory activity. For example, if we have to take enforcement action to make the service improve, or if we investigate and agree with a complaint someone makes about the service.

We gave the service these grades

Quality of Care and Support	4	Good
Quality of Environment	4	Good
Quality of Staffing		N/A
Quality of Management and Leadership		N/A

What the service does well

The service continued to have very good opportunities for relatives and service users to become involved in the development of the service. Despite there continuing to be a lack of response, the service continued to promote and develop opportunities.

What the service could do better

The service could improve outcomes for service users by making sure that areas for development under Quality Statement 1.3 and 2.2 are addressed. These included completion of fluid and food intake charts, review of certain medication times, improving storage of outside bins and full completion of maintenance books.

What the service has done since the last inspection

Since the previous inspection, the service had met three out of four requirements made and all of the nine recommendations made. The repeated requirement is in relation to correct storage of outside bins/bin areas.

Conclusion

While the service had made improvements since the previous inspection, this report highlights some areas for further improvement. The inspectors however acknowledge that the service continued to work hard to make improvements within the service particularly in relation to the environment.

Who did this inspection

Beth Lynagh
Lorraine McIntyre

1 About the service we inspected

Cumbernauld Care Home is purpose built on two levels and is registered to accommodate a maximum of 52 people with mental health problems. There are adequate parking facilities and the home is accessible by public transport.

The care home has a contractual arrangement with Lanarkshire NHS Trust to provide a dedicated service for 52 service users referred directly to the home from NHS facilities.

There are 47 bedrooms in total. 42 of these are single and 5 are twin. All bedrooms have limited en suite facilities.

At the time of the inspection there were 38 service users using the service

Before 1 April 2011 this service was registered with the Care Commission. On this date the new scrutiny body, Social Care and Social Work Improvement Scotland (SCSWIS), took over the work of the Care Commission, including the registration of care services. This means that from 1 April 2011 this service continued its registration under the new body, SCSWIS.

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

Quality of Care and Support - Grade 4 - Good
Quality of Environment - Grade 4 - Good
Quality of Staffing - N/A
Quality of Management and Leadership - N/A

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change following other regulatory activity. You can find the most up-to-date grades for this service by visiting our website www.careinspectorate.com or by calling us on 0845 600 9527 or visiting one of our offices.

2 How we inspected this service

The level of inspection we carried out

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed the service may need a more intense inspection.

What we did during the inspection

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed that the service may need a higher level of inspection.

The inspection was carried out on 10 September 2012 between the hours of 9.30 am and 5.30.pm. Feedback was given to the Acting Home Manager, Depute Manager and one of the staff nurses at the end of the inspection.

During the inspection evidence was gathered from a number of sources

We looked at a range of policies, procedures and other documentation including the following:

* Care plans of 4 service users
* Minutes of service users' / relatives' meetings
* Sample of staff recruitment files
* Accident and incident records
* Complaints log
* Maintenance log
* Supporting evidence from the up to date self assessment
* Public liability insurance certificate
* Registration certificate

And we spoke with the following people:

* 2 service users
* 1 relative
* The acting manager
* 4 staff members

Observation of care practice and a review of the environment and resources was also undertaken.

All of the above information was taken into account during the inspection process and was reported on.

Grading the service against quality themes and statements

We inspect and grade elements of care that we call 'quality themes'. For example, one of the quality themes we might look at is 'Quality of care and support'. Under each quality theme are 'quality statements' which describe what a service should be doing well for that theme. We grade how the service performs against the quality themes and statements.

Details of what we found are in Section 3: The inspection

Inspection Focus Areas (IFAs)

In any year we may decide on specific aspects of care to focus on during our inspections. These are extra checks we make on top of all the normal ones we make during inspection. We do this to gather information about the quality of these aspects of care on a national basis. Where we have examined an inspection focus area we will clearly identify it under the relevant quality statement.

Fire safety issues

We do not regulate fire safety. Local fire and rescue services are responsible for checking services. However, where significant fire safety issues become apparent, we will alert the relevant fire and rescue services so they may consider what action to take. You can find out more about care services' responsibilities for fire safety at www.firelawscotland.org

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

The requirement

The provider must ensure that all staff receive training relevant to tasks they are to undertake. This requirement has been made in relation to one of the service users who required physical intervention in order to avoid injury to themselves and others.

What the service did to meet the requirement

There had been a range of staff training offered which included both statutory and non-statutory training.
We saw that a high percentage of staff had undertaken mandatory training. Staff had also attended other training which was specifically to meet the needs of service users.

The requirement is: Met

The requirement

The provider must ensure that all manual handling techniques used with service users are safe and in line with current best practice guidelines. Techniques must also be subject to a suitable and sufficient risk assessment.

What the service did to meet the requirement

We saw that staff moved service users in line with Manual Handling best practice guidance.

The requirement is: Met

The requirement

The service must ensure that environmental concerns are addressed in that:
* Sharps boxes adequately store sharps and are replaced when full.
* Clinical waste bins outside the building are locked.
* The treatment room temperatures must be kept within best practice guidelines.
* Drug fridges must be regularly defrosted and temperatures kept within best practice guidelines.

What the service did to meet the requirement

We saw that although there had been a number of environmental improvements since the previous inspection, the outside waste disposal bins were still unlocked or in an unlocked bin store.
(See requirement 1, Quality Statement 2.2)

The requirement is: Not Met

What the service has done to meet any recommendations we made at our last inspection

1. Action plans should be developed to demonstrate how ideas raised at the service users and relatives' menu committee had been actioned.
Progress: we saw that there were suitable action plans which reflected actions taken following consultation exercises.
MET

2. An audit should be carried out to make sure all relevant sections of service users' care plans have been signed by themselves or their next of kin.
Progress: The service had person centred care plans which showed where there had been involvement with service users and family. These were audited regularly by management, and discussed at the care reviews with service users and their representatives.
MET

3. The service should make sure that all sections of service users' care plans are fully completed.
Progress: we saw that the sample of care plans we looked at had been fully completed. The manager had audited the quality of the care plans frequently.
MET

4. Food temperature charts should be fully completed to record what measures were taken when food temperatures are below the acceptable temperature before serving.
Progress: Records showed that food temperatures had been carried out before meals were served.
MET

5. The service should continue to develop the internal areas in line with current best practice relating to signage on bedroom doors and bathrooms.
Progress: The service had made progress in relation to the improvement of signage on bedroom doors and bathrooms.
MET

6. Where references are received and only contain statistical information, the service should seek out a further reference relating to the individual's character.
Progress: We looked at a sample of staff recruitment files and saw that safe recruitment policies had been followed.
MET

7. Supervision records for staff should clearly show where training suggestions have been made by staff and the action taken about these suggestions. The supervision records should also show points for actioning form the last supervision.
Progress: Staff supervisions took place regularly. The Manager carried out a training analysis from staff supervisions to identify where extra training was required.
MET

8. The manager should look to promote leadership values through delegation of work e.g. encouraging the completion of the care standards questionnaires and getting relatives more involved in the development of the service. This should be taken into consideration along with the key worker role.
Progress: The manager had introduced several ways to do this. These are reflected under Quality Statements 1.1 and 1.3
MET

9. The service should ensure that accidents and incidents audits are able to establish which service users the information is about.
Progress: accidents and incidents audits now reflected this information.
MET

The annual return

Every year all care services must complete an 'annual return' form to make sure the information we hold is up to date. We also use annual returns to decide how we will inspect the service.

Annual Return Received: Yes - Electronic

Comments on Self Assessment

Every year all care services must complete a 'self assessment' form telling us how their service is performing. We check to make sure this assessment is accurate.

A fully completed self assessment document was submitted by the service. This was completed to a satisfactory standard and gave relevant information for each of the Quality Themes and Statements. The service identified its strengths and some areas for future development.

Taking the views of people using the care service into account

We spoke with some of the service users within the service however, due to their medical diagnosis, their conversation was limited. They did however seem to be happy within their surroundings and interacted well with staff.

Taking carers' views into account

Before the inspection, we sent out 25 relatives questionnaires but had no returns. 2 carers were spoken with during the inspection. They all spoke very positively about the care their family members received. Comments included:

* 'the environment is really coming on'
* 'I'm really happy about dad being in here - the staff are great'
* Mum can be a challenge but the staff are so good with her'
* I can really see improvements being made recently'

3 The inspection

We looked at how the service performs against the following quality themes and statements. Here are the details of what we found.

Quality Theme 1: Quality of Care and Support

Grade awarded for this theme: 4 - Good

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths

The service had a complaints policy. We saw that there had been one complaint to the service that had been fully and satisfactorily investigated.

6 monthly reviews were carried out. All had been signed appropriately by either relatives or service users.
Care reviews were attended by members of the nursing team, the liaison nurse if further input was required and the service users' key worker.

Questionnaires were given out 6 monthly to relatives in advance of service users' care reviews, and asked for feedback about the service generally. This meant that relatives and service users where able, would have time to consider their answers to the questions before their review. This was then returned, discussed at the review and actioned where able.

Customer satisfaction surveys were carried out annually, and any areas for improvement noted had action plans developed.
We saw the customer satisfaction survey results for 2012. These were generally easy to follow and used graphs. The overall questions were in plain English, which meant that it was easy for readers to follow.
We saw a letter which was posted out by the acting manager. This showed the actions that had been taken by the service about issues raised through the survey. It stated that the results of the survey would be discussed at the next relatives/service users' meeting.

Relatives/service users' meetings were planned every three months. The service had also arranged monthly tea mornings/afternoons, the times of which were varied in an attempt to encourage relatives to attend. Information was displayed about these

events on the notice boards.

Relatives were also invited to attend different groups and committees within the service; however no one had attended recently.

The manager made their self available to discuss any concerns or issues that relatives/service users may have with the service provided through an open door policy.

Manager's surgeries had also been planned. Dates and times (including weekends) were displayed on the notice board to inform people.

We saw that a specific activities meeting had been held and that four service users had attended this. Relatives had also been invited. Minutes showed where service users were asked their preferences and these were accommodated or arranged.

Service users' choices were displayed on the notice board in relation to activities available for people to take part in. The boards demonstrated lots of evidence of activities planned for the week for each unit.

The service had a wish tree. This showed what people had wanted in relation to making choices within the service such as outings. We saw lots of pictures displayed throughout the service which showed service users involved in activities.

The service had a suggestion box at the entrance where people could make comments or suggestions in confidence.
Monthly themes had been developed for the suggestion box responses. This was to help encourage people to put forward ideas and provide information that may improve the service. The suggestion box was checked on a weekly basis, and any issues highlighted from these questionnaires would be acted on if appropriate.

The service had a key worker system in place. This meant that certain staff were responsible for the day to day care and support of service users and their relatives. The role of the key worker had been discussed at the activities meeting with staff.

The service had person centred care plans which showed where there had been involvement with service users and their family. These were audited regularly by management, and discussed at the care reviews with service users and their representatives.

Relatives had been invited to become involved in the service's Health and Safety audit; however no one had wished to become involved.

Relatives had also been invited to take part in new staff interview processes; however no relatives had wished this. Questionnaires had been issued to relatives to identify

what qualities they would like potential new staff to have - we saw that this was now part of the standard interview process.

Relatives and service users had been encouraged to participate in the refurbishment of the home and garden areas. Lower and upper unit bedroom doors had been painted after consultation with service users and relatives and they had been invited to join the 'Themed Corridor Committee'.
Some of the garden refurbishment had also been completed, after consultation with relatives at meetings. Service users had been involved in the development of the new vegetable garden. One service user told us that they had eaten some of the strawberries which they had helped grow.

Dates of staff meetings were displayed throughout the unit. These invited relatives to inform the manager of any points that they wished to be added to the agendas Relatives had also been invited to attend staff training for a 'greater understanding of the role of staff and what is expected by Four Seasons Health Care'.

Care plans had an agreement form in place. This was designed to be signed by relatives or service users when the care plan was developed or updated. The forms recorded how the service had communicated with relatives where they were not available in person.

Information on local advocacy services was displayed in prominent areas throughout the home. This helped to raise awareness of people about their right to be represented by advocacy services.

There was a service user guide located within bedrooms. This let service users and their relatives know more detailed information about the service and help them to make choices.

A newsletter was given out regularly. This informed people of organised events and activities within the home e.g. when the psychiatric consultant was available, management arrangements and results of the most recent Care Inspectorate inspection. The newsletter also reminded people about all the committees, meetings and tea afternoons which they could become involved in. Relatives were invited to speak with management if they were unable to attend any of these events, but wished to put their views forward.

The newsletter also advised readers about:
* Positively Enriching and Enhancing Residents Life (PEARL) award which the service was working towards,
* Garden developments - including how service users were involved
* E-mail opportunities
* Feedback on charity events.
Copies were displayed on notice boards and extra copies were made available at the

front door for other visitors to the unit.

"Choices" toolkits had been purchased for both floors. These helped to aid communication of residents with impaired communication and helped to identify their likes/dislikes and wishes. At the time of the inspection, these were being fully introduced throughout the service.

Life history works were being developed by key workers in consultation with relatives and service users.

The service had introduced ways in which people could contact the service. People were informed about this in posters which were displayed at the front entrance.

Areas for improvement

Photographs on the wall had handwritten information beside them. They were difficult at times to read and were often written in a way which was not user friendly. Improving the information, could help in involving service users in discussions about the pictures.
We also saw that there was some formal letter displayed in service users communal areas which would have been better stored for information elsewhere. This was in relation to direct correspondence between the service and a local MSP in relation to funding for the garden project. It was discussed at the time, that this may have been more useful information had it been developed into an easier read format for people to read.
(See recommendation 1)

The service should continue to introduce the recently purchased Choices Communications tools throughout the service and staff.

Although we were told that relatives' meetings had no attendees, records should be kept to reflect this.

Grade awarded for this statement: 5 - Very Good

Number of requirements: 0

Number of recommendations: 1

Recommendations

1. Information displayed in service user areas should be considered as to whether it is relevant. In doing so, relevant information should be displayed and communicated in a way which is easy for service users to understand.
   National Care Standards: Care Homes for Older People, Standard 11 - Expressing your views.

Statement 3

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

Service strengths

PEARL award meetings were held and attended by staff. These looked at different areas and with a shared input from staff, discussed how these could be improved e.g. the menu and how to get a better dining experience for service users such as seating planners.

We saw that service users were well dressed and presented during the inspection. Service users and relatives told us that they were happy with the level of care and support they received and the professionalism of the staff and management.

We saw evidence where service users' clinical needs had been assessed, investigated and addressed; these included monitoring how much people drunk or ate daily as well as pressure relief. Where required, there had been clinical input from healthcare professionals.
Specific clinical assessments and tools were also being used E.g. Cornell Scale for Dementia and Depression

All service users who had been assessed as being clinically at risk e.g. weight loss, were monitored by the provider's senior management via their internal recording system. Appropriate action was agreed and taken by the service where required.

Care plans we saw, recorded how specific service users' clinical and social needs would be met. This meant that staff had a clear direction in how to care for the service users. Care plans and specific clinical assessments were reviewed by nurses on a monthly basis or more frequently as required. We saw some good examples where staff had been proactive in dealing with service users' specific needs.

We saw that where legally required, care plans had appropriate Adults with Incapacity forms and treatment plans attached. End of life had been recorded in a good level of detail. There were also copies of the legal documents which gave relatives powers in relation to decision making on behalf of service users.

Staff nurses require to be registered with the Nursing and Midwifery Council. The service carried out checks monthly which helped to keep them aware of any issues relating to staff's professional qualification. This helped to make sure that staff were still appropriately qualified to care for service users.

The service had continued to develop the environment to help meet service users' needs. Menu boards were available in both units and pictorial signage was used to help service users with communication difficulties have a more enjoyable and personable dining experience.
Memory boxes were in place at each service user's bedroom to help orientate them to

their own personal space and belongings.

Three monthly menu committees were held. These were attended by nursing staff, management and the cook. Residents and relatives could also attend if they wished. We looked at the minutes of this committee meeting and saw that actions had been taken as a result of issues raised and discussed. The service had taken positive steps to encourage those service users with poor appetites.

The provider had a recruitment policy and procedure which made sure that staff were suitably skilled and qualified to work in the service.

There had been a range of staff training offered which included both statutory (legally required) and non-statutory training.
We saw that a high percentage of staff had undertaken mandatory training. E.g. Food Hygiene, Health and Safety, Infection Control and Fire.
Staff had also attended other training which was specifically to meet the needs of service users. The training helped to make sure staff were suitably skilled to do this.

The service supported some staff in their roles as clinical champions. This meant that specific staff were more skilled in certain clinical areas and could provide support and advice to other staff.

Staff supervisions took place regularly. The Manager carried out a training analysis from staff supervisions to identify where extra training was required to meet the needs of service users.
Annual appraisals of staff had also been undertaken to discuss their professional development.

The service frequently carried out a range of audits. Any actions found to be required were highlighted and the Manager then rechecked these at a later date to ensure that the actions required had been carried out.

Audits of accidents and incidents were also undertaken to help identify trends and any intervention required i.e. equipment and specific monitoring.

We looked at a sample of medication recording sheets and found these to have been fully completed with staff signatures. Where a service user had not received their medications, the reason was clearly recorded.
Drug storage areas were appropriately stored and temperatures recorded for these areas.

A 'pool activity level' (PAL) assessment was recorded in service users' care plans. Records reflected how the specific activity helped to promote service users' wellbeing. The assessment also gave staff an understanding of service users' abilities and individual plans were developed as a result.

PAL meetings had also been developed to discuss ideas with other activity coordinators and share ideas.

The service had designated activities staff, whose role it was to co-ordinate activities and events for service users. One of the staff discussed the plans for the development of the sensory room.

Specialised equipment was used where required such as bathing equipment; hoists and assistive technology e.g. pressure mats. Special utensils and cups were used to maintain service users' independence.

Dependency levels were monitored frequently. This helped to make sure that there were enough staff to meet service users' needs.

Areas for improvement

Fluid and food intake charts were not always being completed in line with instructions and did not clearly show if targets were being reached. Dietary charts did not always reflect quantities of food taken by service users.
(See requirement 1)

We saw two service users who were regularly asleep when they were due to receive their 10pm medications. It was agreed with the acting manager that this service user's medication times would be reviewed.

Although PAL records had been completed and scored, they did not always have any reference sheet which showed what the score represented. The service should make sure that this information is inserted into care plans for easier referencing and auditing purposes.

Grade awarded for this statement: 4 - Good

Number of requirements: 1

Number of recommendations: 0

Requirements

1. The provider must ensure that fluid and food intake monitoring charts are fully completed and accurately reflect service users' daily intake
   This is in order to comply with: SSI 2011/210 Regulation 4 - Welfare of service users
   Timescale for implementation: on receipt of this report.
   Timescale: On receipt of this report.

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 4 - Good

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

Service strengths

See comments under Quality Statement 1.1

Areas for improvement

See comments under Quality Statement 1.1

Grade awarded for this statement: 5 - Very Good

Number of requirements: 0

Number of recommendations: 0

Statement 2

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

Service strengths

We saw that areas of the home were welcoming and clean and fresh with good access for residents to lounges, bedrooms and dining areas.
We saw domestic cleaning records. These records showed that areas of the home were cleaned regularly and in line with guidance.

The interior garden area had been developed since the previous inspection. The layout made sure that service users would remain safe and secure and could be monitored by staff without encroaching on their privacy. We saw that staff were working on developing the next phase of the garden with raised flower beds being completed. This would help service users to become involved in taking part in planting within these areas.

Outdoor activities had been promoted in the new garden area which could help with service users' mobility, coordination and stimulation. We were also told how the service planned to develop a sensory garden.

Service users could have their own personal keys to their rooms and could dine in the privacy of their own rooms. Lockable drawers were available in all bedrooms for service users to store personal items securely.

Staff followed best practice guidance in relation to food temperature recording prior to serving.

The service had continued to develop the dementia friendly signage within the home. This continued to be a work in progress and the acting manager discussed the future environmental plans to improve this further.

There were appropriate systems in place to ensure the safety and wellbeing of residents. These included maintenance checks such as water temperature checking and six monthly hoist checks. The service also had a range of policies including Infection Control, Risk Management and Health and Safety.

The service had a controlled door entry system which meant staff knew if anyone wanted to come into the building. Visitors had to sign the visitors' book. The door also meant that service users were safe and secure.

Staff demonstrated good infection control practices through the use of appropriate protective clothing depending on the task which they were undertaking.

Environmental audits were carried out frequently. We saw where the service had been proactive in developing practice to address issues raised through audits.

The service continued to work towards achieving the PEARL award scheme. Part of this included the development of the environment in line with best practice dementia guidance.

Control of Substances Hazardous to Health training was mandatory for all staff. We saw that staff were following correct storage of chemicals and cleaning agents.

Areas for improvement

We saw that although there had been a number of environmental improvements since the previous inspection, the outside waste disposal bins were still unlocked or in an unlocked bin store.
(See requirement 1)

We looked at the maintenance book and saw that it was inconsistent at times in how it was recorded that actions had been taken where actions were required.
(See recommendation 1)

A number of small environmental issues were passed onto the acting manager at feedback such as storage of towels and length of nurse pull cords in bathroom areas. The service should continue to monitor the condition of the environment on a frequent basis with a view to improving practices.

Grade awarded for this statement: 4 - Good

Number of requirements: 1

Number of recommendations: 1

Requirements

1. The service must ensure that environmental concerns are addressed in that:
   * Sharps boxes adequately store sharps and are replaced when full.
   * Clinical waste bins outside the building are locked.
   * The treatment room temperatures must be kept within best practice guidelines. Seen to be 23-27 (should be no more than 25)
   * Drug fridges must be regularly defrosted and temperatures kept within best practice guidelines.
   This is in order to comply with: SSI 2011/210 Regulation 4 - Welfare of service users
   Timescale for implementation: on receipt of this report.

Recommendations

1. The maintenance book should clearly demonstrate where actions have been completed to address areas of deficit.
   National Care Standards: Care Homes for Older People, Standard 4 - Your environment

Quality Theme 3: Quality of Staffing - NOT ASSESSED

Quality Theme 4: Quality of Management and Leadership - NOT ASSESSED

4 Other information

Complaints

No complaints have been upheld, or partially upheld, since the last inspection.

Enforcements

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

Additional Information

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in SCSWIS re-grading the Quality Statement within the Management and Leadership Theme as unsatisfactory (1). This will result in the Quality Theme for Management and Leadership being re-graded as Unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 4 - Good	
Statement 1	5 - Very Good
Statement 3	4 - Good
Quality of Environment - 4 - Good	
Statement 1	5 - Very Good
Statement 2	4 - Good
Quality of Staffing - Not Assessed	
Quality of Management and Leadership - Not Assessed	

6 Inspection and grading history

Date	Type	Gradings	
27 Apr 2012	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed 4 - Good 4 - Good
5 Dec 2011	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed Not Assessed 3 - Adequate
27 Jul 2011	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed Not Assessed 4 - Good
30 Dec 2010	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good 5 - Very Good Not Assessed Not Assessed

1 Jul 2010	Announced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good Not Assessed Not Assessed
15 Mar 2010	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed 5 - Very Good Not Assessed
19 Nov 2009	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed 5 - Very Good Not Assessed
16 Dec 2008	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good 4 - Good
17 Jul 2008	Announced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 4 - Good 4 - Good

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

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ی ہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے-

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هذا المنشور متوافر عند الطلب بتنسيقات وبلغات أخرى.

本出版品有其他格式和其他語言備索。

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