Ashford House
Care Home Service

7 Claremont Drive
Bridge of Allan
Stirling
FK9 4EE

Telephone: 01786 833950

Type of inspection: Unannounced
Inspection completed on: 2 November 2017

Service provided by:
Mauricare (Drumpark) Limited

Service provider number:
SP2012011881

Care service number:
CS2012310157

About the service

Ashford House is situated in the town of Bridge of Allan and is registered to provide care for up to 23 older people. At the time of the inspection 20 people were residing in the home. Ashford House does not have registered nurses onsite. Management, along with the local authorities, have to ensure that they can meet the assessed needs of people considering the home.

Ashford House is a traditionally built Victorian property with two storey accommodation. The home offers a communal lounge and dining area. There is one double bedroom which offers accommodation if required for a couple, the remaining number are single rooms. Some rooms have ensuite toilets and hand wash facilities and this is an area that the provider should improve upon. A chair lift provides access to the first floor, there is no lift. There are communal bathrooms available for people's use on both floors; however, at the time of the inspection only two out of four bathrooms were available for people's use.

The home is situated just out of the main town in a residential setting. The grounds are undergoing improvements and the provider acknowledges that the garden space could be further adapted to allow greater use.

Mauricare were registered as providers of the care home in October 2012. The Mauricare group has two other care homes in Callander, Scotland. The provider manages other care homes in England.

The service aims are as follows:

"To provide a comfortable care home in pleasant surroundings enjoying a relaxed, happy and friendly atmosphere. The aim of Ashford House is to provide a home for the residents and as such will provide a high standard of care to meet the physical and emotional needs of all residents. This will be done with dignity and privacy at all times, and involves residents with decisions about daily living."

What people told us

We spoke with eight residents throughout our inspection. We received back 11 Care Standard Questionnaires (CSQs) we asked the home to randomly distribute to residents and relatives.
Comments made in person to us and in the CSQs were used to inform our report and included:

"I cannot speak highly enough of the care my mum receives. She is settled and content and the staff at Ashford House are so helpful and caring towards her."

"Has been a lot of new staff and hopefully when they are settled there will be a big difference. As for my mum she thinks that it is a 5 star hotel as her dementia has advanced and I am the voice for her.....enough clothes in wardrobe and drawers have been mum's...mum's happy but sometimes I have not been. Hopefully with the new manager things are changing. This is the first time in 2 years that I have had a form to complete and I am grateful for that."

"I'm happy, no moans. Staff all do what they can. I've no complaints about here. Staff friendly and seem to know what they are doing."

Self assessment

We are not requesting a self assessment from services this year, referring to the service's own development plan instead.

From this inspection we graded this service as:

Quality of care and support	2 - Weak
Quality of environment	1 - Unsatisfactory
Quality of staffing	3 - Adequate
Quality of management and leadership	2 - Weak

Quality of care and support

Findings from the inspection

Staff were very visible within the public area of the home, and were kind and responsive in their interactions with residents. Residents appeared nicely dressed, wearing colour co-ordinating clothes. We could see that visitors were made welcome, and the lounge area was lively, with people coming and going. Staff seemed very familiar, not only with residents, but with their visitors.

Pre-assessments completed by the service could be improved. This information demonstrates that the service is aware of the individuals' health and social care needs prior to residents' admission and is confident that they can meet them. This forms the basis of effective care planning which meets residents' needs and promotes good outcomes.

In order to ensure that there are enough staff on duty with the necessary experience and differing skills required to meet the needs of residents and to ensure they get the care and support they need when they need it, the service need to have an overview of all residents' needs and requirements on a day-to-day basis. The service uses an augmented IORN tool to do this. The information we would expect to see in such a document was not there, for example there was no information about how to assist with bathing, and continence care was only partially addressed. These are fundamental areas of the daily care of elderly people. Furthermore, if the dependency tool used does not make clear the level of support that residents need, then this could have a knock on effect on the adequacy of staffing levels which does not promote the best outcomes for residents in terms of meeting their needs.

Care planning lacked a person centred approach and therefore adequate information on the person's individual support needs which could affect people getting the help they need in the way that they want it. Risk assessments and care plans frequently contradicted each other instead of clearly intersecting and forming a cohesive picture of the residents' needs, the care required and how best to provide it. (See Requirement 1).

We saw that residents' weights were not being managed well, with weight losses not being investigated or accounted for. This could leave residents not receiving the support they need to maintain a healthy weight. (See Requirement 2). We found a similar story with fluid intake. (See Recommendation 1). Other examples were shared with the management team at feedback.

The environment of the service is disabling, with residents who reside upstairs, in particular, not being able to easily get around. There is no lift within the service. We found one resident who had recently had a fall, could not get out of her room and was at risk of social isolation as a result. This had not been considered or acted upon. There is only one lounge within the service, which is quite small for the number of residents within the home and which does promote residents' choice in being able to spend time in either a busy TV lounge with lots of visitors and a quieter area.

Requirements

Number of requirements: 2

1. The provider must put in place a system to ensure that personal care plans:
- state individuals' specific health needs and associated risks.
- quickly identify the priority needs of an individual when they move into a care home.
- record under which circumstances relatives/friends are to be contacted if key events take place for an individual.
- provide clear and accurate information and guidance for staff on how to meet the identified needs and risks.
- evidence that assessment tools are used effectively and accurately to identify individuals' needs and are updated regularly and as individuals circumstances change. This must include falls risk assessments.
- are reviewed regularly and updated to include changes as a result of a planned care review or when there is a change in an individual's needs.
- contain clear assessment and evaluation information regarding individuals' needs and planned interventions by staff to meet these needs.
- ensure people's manual handling needs are clearly identified through assessment.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. Scottish Statutory Instrument 210: Regulation 3 - Regarding the principles of the Act. Regulation 4 (1) (a) - Welfare of users. **Timescale:** 28 February 2018.

2. The provider should develop, implement and regularly review an effective procedure for assessing, managing and monitoring service users at risk of malnutrition.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. Scottish Statutory Instrument 210: Regulation 4 (1) (a) - Welfare of users. **Timescale**: 28 February 2018.

Recommendations

Number of recommendations: 1

1. The service should ensure that fluid charts are filled out and completed correctly in order to ensure that residents who require this level of support receive it as they should.

National Care Standards Care Homes for Older People : Standard 14.

Grade: 2 - weak

Quality of environment

Findings from the inspection

We discussed with the management team environmental improvements which had been made to the home. We also looked at the original conditions of registration, and assessed to what degree (if any) they had been achieved.

We found the following:
- The refurbishment of the first floor, which was action planned in 2012 (and intended to be completed in October 2013) is now action planned for 2018.

- The repair and refurbishment of the windows in the home, action planned in 2012 and due to be completed by now, has not been actioned as we would have expected. To date only the living and dining room windows have been done. Work seems to be being done on an adhoc basis and not consistently.

- There was no hot water on the first floor during the time of inspection.

- In the bathroom downstairs, the hoist is not working.

- The kitchen has not been upgraded or refurbished in any way, this was a condition of registration in 2012 also, and should have been completed by now.

- There is no closed door between the kitchen and the laundry.

- The laundry has not been upgraded or refurbished in any way, this was a condition of registration in 2012 also. Furthermore one sink is being used as a sluice, which is very bad infection control practice.

- The staff toilet for use by the laundry/kitchen staff requires to be upgraded.

- In the upstairs hallway, the paper is peeling off, the paper doesn't match and there are visible scuffs on the bottom half.

- The upstairs bathroom (directly at the top of the stairs) is not accessible.

- Many toilets are on small, raised wooden plinths.

- The other bathroom upstairs has a manual hoist which is not working.

- Maintenance checks were not being fully completed.

The environment as it stands is extremely disabling for residents in many ways. The lack of a lift makes easy access up and downstairs difficult for residents upstairs. This means residents tend to come downstairs in the morning and stay downstairs and the lounge is of a small size for residents to be in all day. It's busy and noisy and there is no quieter alternative for people apart from their own rooms.

Upstairs the hallway is dark, the lighting should be improved as at the moment it does not promote safe ease of movement for residents who have a visual or cognitive impairment.

Upstairs the bathrooms are unfit for purpose for elderly people to use safely, easily and with dignity. One is so small it's difficult to see how residents requiring support could receive it comfortably with the door closed. Both are poorly equipped. The décor is tired and does not feel homely.

There was no hot water upstairs at the time of inspection meaning residents upstairs had to come downstairs to be changed or bathed this does not promote, choice, privacy or dignity for residents.

The kitchen is badly equipped with domestic equipment in place which is not satisfactory to provide food for more than 20 adults every day. There are no coverings on any cupboards meaning good infection control is not in place, which could affect the health and wellbeing of residents. We saw no fresh fruit, meat or vegetables during inspection.

The laundry is unfit for purpose, with only one entry route when there should be two. The room is too small, meaning it is impossible to separate soiled and fresh laundry as it should be. This is an infection control issue which could affect the health and wellbeing of residents.

Overall the above lack of care and attention demonstrates that the provider does not value the environment in which residents are expected to live. (See requirements 1 and 2).

Requirements

Number of requirements: 2

1. To ensure that everyone who uses the service is able to access and use their environment safely and without restrictions the service must develop an action plan that details how and when the works identified in this report will be completed by. The priorities for work to be completed and all timescales for completion will be agreed with the Care Inspectorate.

Timescale: 28 February 2018

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. Scottish Statutory Instrument 210:
Regulation 3 - Regarding the principles of the Act Regulation 4 (1) (a) - Welfare of users. Regulation 10 - Fitness of Premises

2. To maximise the safety and living experience for people the service must carry out the identified works detailed within the action plan by the completion dates agreed with the Care Inspectorate.

Timescale: All work to be completed by October 2018.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. Scottish Statutory Instrument 210:
Regulation 3 - Regarding the principles of the Act. Regulation 4 (1) (a) - Welfare of users. Regulation 10 - Fitness of Premises.

Recommendations

Number of recommendations: 0

Grade: 1 - unsatisfactory

Quality of staffing

Findings from the inspection

There was a nice, friendly atmosphere within the home. Staff were responsive and caring towards residents, and clearly knew them and their visitors well. Residents and visitors we spoke to, and responses received from our Care Service Questionnaires were positive and complimentary about the staff within the service. We looked at the service's policies and procedures with regard to recruitment and found that they were fine. Recruitment is ongoing, and new staff have recently been recruited for the service.

The quality of the service's recruitment and induction procedures in action were of mixed quality, we found examples of good practice and poor practice in different files sampled, and these were discussed in depth with the management team at feedback. The service should audit these files at regular intervals in order to determine what works for them, to improve their own quality assurance procedures with regard to recruitment and induction and to evidence the efficacy of these procedures in recruiting and inducting staff well in order to best meet the needs of residents living within the home. We saw, among other things, that photographic evidence of identity was not being kept and that interview notes were not always completed (all the more crucial when references do not always contain a lot of detail).

Staff said that the 5 day induction met their needs in terms of understanding their role, and that the training and support they were given was good. As above, the service should assess new recruits understanding of the learning they have undertaken during the induction process via (for example) questionnaires, direct observations of practice and supervision sessions in order to evidence their progression and to identify any shortfalls in training or understanding at an early stage.

Staff meetings were held regularly and a wide variety of issues pertaining to the daily life of the home were discussed, including good practice and expectations of staff. The service could develop these further to include current best practice guidance, policies and procedures (we found staff who were unaware of the whistleblowing policy for example) and possibly as group supervision sessions to address particular areas of practice, such as the recording of fluids and weights, care planning and risk assessment tools to augment and support their training schedule. (See recommendations 1 and 2).

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 2

1. The service could utilise their regular staff meetings better to update staff on best practice guidance and to support their ongoing training programme.

National Care Standards Care Homes for Older People Standard 5.

2. The service should ensure that regular supervision and appraisal are made available to support staff and ensure that their training and personal development meet the needs of the people living in the service. National Care Standards Care Homes for Older People Standard 5

Grade: 3 - adequate

Quality of management and leadership

Findings from the inspection

The manager of the home is not long in post, having transferred from another home within the group, and is still settling in to her new role. There is support from a Regional Manager to assist with this transition.

Auditing within the service needed to improve to promote better outcomes for the people living in the service, across all quality themes. Care planning in particular needs to be more cohesive and to achieve that, staff need better training and appraisal of their work in this area. Recruitment and induction is another area of concern. Auditing will give the manager and senior team a starting point from which to identify the strengths and weaknesses within the service in terms of the Care and Support, the Environment and Staffing and how to formulate an action plan that will take the service forward in a positive direction. (See Requirement 1).

The Environment is unsatisfactory and the issues mentioned within this report, and discussed at feedback, require to be addressed as a matter of urgency.

A good range of training was available, both classroom based and via online learning. There was little evidence to show which staff had attended and how effectively staff were putting this training into practice. This could be addressed via supervision and appraisal cycles, but we could see that supervision and appraisal was not happening on a regular basis, and when it was it was often poorly recorded. This means that the senior team are not evidencing the work they do in ensuring that staff are well trained, supported and supervised as they should be. It also means that staff development and ongoing training, areas of strength and improvement are not being clearly identified and actioned which is important to ensure a confident staff team, with a strong skills mix who can meet the ongoing challenge of caring for residents with a range of complex needs.

Requirements

Number of requirements: 1

1. The provider must develop and implement an effective system of quality assurance to identify and action the required improvements within the service. This includes developing an action plan on how, and by when, the improvements will be met.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. Scottish Statutory Instrument 210:
Regulation 3 - Regarding the principles of the Act, Regulation 4 (1) (a) - Welfare of users, Regulation 9 - Fitness of Employees, Regulation 10 - Fitness of Premises. **Timescale:** 28 February 2018.

Recommendations

Number of recommendations: 0

Grade: 2 - weak

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

Previous requirements

Requirement 1

Requirement with reference to Theme 1: Care Planning

The provider must put in place a system to ensure that personal care plans:
- state individuals' specific health needs and associated risks.
- quickly identify the priority needs of an individual when they move into a care home.
- record under which circumstances relatives/friends are to be contacted if key events take place for an individual.
- provide clear and accurate information and guidance for staff on how to meet the identified needs and risks.
- evidence that assessment tools are used effectively and accurately to identify individuals' needs and are updated regularly and as individuals' circumstances change, this must include falls risk assessments.
- are reviewed regularly and updated to include changes as a result of a planned care review or when there is a change in an individual's needs.
- contain clear assessment and evaluation information regarding individuals' needs and planned interventions by staff to meet these needs.
- ensure people's manual handling needs are clearly identified through assessment.

This requirement was made on 4 January 2017.

Action taken on previous requirement

The management had started to renew people's plans of care, and some evaluations had been updated. Work had not progressed as we had expected.

We shared several examples with the management team where improvements were required. We discussed specific concerns about night staff's understanding of record keeping. It was disappointing to note that people's preferences and routines were not evident in relevant plans. There is a need for management to delegate completion of care plan updates with clear timescales in place and we expect this level of detail in the action plans we require from the service.

Not met

Requirement 2

Requirement with reference to Theme 1: Weights

The provider must be able to evidence that people at risk of malnutrition have their weight monitored on a regular basis. This may be assessed as required weekly or monthly for monitoring and evaluation purposes. The service must adhere to this monitoring programme in order to protect people identified at risk of malnutrition.

This requirement was made on 4 January 2017.

Action taken on previous requirement

We found that monthly weights were now being documented consistently but that weekly weights were not. For example, one person required to have their weight taken weekly in accordance with their care plan. This task was not being undertaken and staff were unsure about who did require to be weighed weekly. This raised some concerns as low weights were not being monitored or evaluated as required.

Evidence showed that people's food and fluid charts were not being completed properly as information was not showing what people had consumed, and only what was offered. As a result, some people's nutritional intake was not being monitored effectively. We also found that the information recorded about people's specific dietary needs was not consistent. The service had introduced an NHS communication and mealtime toolkit - which the cook we met was not familiar with.

Not met

Requirement 3

Requirement with reference to Theme 3: Staff's registration with professional bodies:

A provider must not employ any person in the provision of a care service unless that person is fit to be so employed. This includes a person who, in order to perform the duties for which the person is employed in the care service, is required by an enactment to be registered with any person or body and is not so registered.

This requirement was made on 29 June 2015.

Action taken on previous requirement

In the summary sent to us from the manager this evidenced that 50% of the care staff are still to register with the SSSC. We have asked the area manager to assess this further and report back to us.

Met - outwith timescales

Requirement 4

Requirement with reference to Theme 3: Staff Training and development:

The provider must demonstrate proper provision for the safety and welfare of service users is made. In order to achieve this the provider must:

- Ensure that at all times suitably qualified, skilled and experienced staff are working in the care service in such numbers as are appropriate for the health and welfare of service users.

- Ensure all staff have access to regular training appropriate to the work they do and to meet people's needs. This must include staff who are competent in managing the safety of people in an emergency situation and in the moving and handling of people.

- Have systems in place to guide each staff member in their practice and ensure that each staff member is meeting expected standards of practice.

This requirement was made on 4 January 2017.

Action taken on previous requirement

The provider had sourced a new training provider who was working with the area manager to assess and plan staff's training requirements. This was in the early stages of development.

There was no evidence that staff had individual Personal Development Plans, that allowed management to measure and evaluate staff's practice and performance.

Plans need to be devised and designed around the member of staff's development needs that incorporates:
- identified training required to undertake their role.
- analysis of how this training has impacted on performance.
- ongoing training including specialist training.
- progression within career.
- ongoing support and detailed supervision that links into the process.

Records and staff discussions showed that training was not up-to-date for all staff members. Some training requirements were mandatory and need to be prioritised. There needs to be a more robust approach to the planning, recording and evaluation of training with ongoing monitoring of compliance.

Staff were not being supervised formally on a regular basis. The senior on duty told us that the last time this had been completed was March 2015. Without this staff practice, training and development cannot be properly monitored, which ultimately can impact on people's care if there is no accountability.

Not met

Requirement 5

Requirement with reference to Theme 4: Evaluation of care:

The provider must identify when there is a significant change in service users' health, welfare or safety needs and review the plan of care to address the need. In order to identify this change in need, a robust evaluation of care information is required.

This requirement was made on 4 January 2017.

Action taken on previous requirement

The evidence we considered through care plans, audits, staff interviews and training records evidenced that this did not happen in a robust and planned manner. For example, we noted that the manager was not signing off accident and incident reports, therefore there was no evidence that management were monitoring accidents and that staff were completing documentation in accordance with internal policy and procedures.

Not met

Requirement 6

Requirement with reference to Theme 4:

The provider must ensure that a quality assurance system is in place which includes contingency plans to ensure that the service is delivered in a planned and consistent way.

In order to achieve this the provider must:
- have a contingency plan, shared with managers, to address absence from any of the management team.

- implement a plan for managers to gain the experience and qualifications to ensure they have the skills to deliver management and leadership within the services.

This requirement was made on 4 January 2017.

Action taken on previous requirement

The managers across the three Scottish homes were scheduled to commence an additional management qualification this month.

We were disappointed that there was no formal contingency plan in place for either the area or home manager's absence and we have directly raised this with the provider. This aspect of the requirement is ongoing.

Not met

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

Previous recommendations

Recommendation 1

Recommendation with reference to Theme 1: Mealtime arrangements.

The service must review the mealtime arrangements to promote an effective, supportive and relaxed mealtime experience and environment, ensuring that prompt support is given to people in relation to nutrition and hydration. Menus should also be reviewed in line with best practice guidance to ensure that they meet the nutritional needs of all people.

This recommendation was made on 12 July 2016.

Action taken on previous recommendation

We advised that the area manager meet with the cooks formally to ensure that all use the NHS dementia mealtime toolkit as expected. We have also advised that a daily delegation sheet be used to guide staff on roles and responsibilities and this should take into account people's food and fluid requirements.

We observed people having breakfast and lunch. Overall, this was a more relaxed and supported meal time experience. People told us that the food was good. We saw people being offered visual choices to choose their preferred meal and the food was well presented. Some practical changes made to the way that people were offered meal choices had happened and, as a result, people were not waiting as long in between courses. This reduced people's agitation.

There were less people resident in the home at this visit. We expect that people's meal time experience is closely monitored to ensure that this improved standard is maintained. We concluded that this recommendation had been met.

Recommendation 2

Recommendation with reference to Theme 1: Pre-admission assessments.

We expect that care services fully assess the needs of people considering their service and then individually tailor care and support needs to meet the health, social, cultural and faith needs of every individual receiving care and support. The care and support plan should outline this from the point of initial assessment and this should be regularly reviewed. This should include information which is received from hospitals or any other sources.

This recommendation was made on 29 June 2015.

Action taken on previous recommendation

We looked at pre-assessments in the care plans and felt they could give a better representation of individuals' health and social care needs prior to entering the home in order that the service can plan how best to meet those needs. The information in this document could form the basis for the residents' care plan. This recommendation is ongoing.

Recommendation 3

Recommendation with reference to Theme 2: Restraint Policy

It is recommended that a policy on restraint is in place. This should take account of bed rails, pressure mats, locked doors and other means required for people's wellbeing and safety. This policy must take into account current best practice guidance.

This recommendation was made on 12 July 2016.

Action taken on previous recommendation

The restraint policy was reviewed in September 2016 and covers the main required areas. This must refer to best practice guidelines. We concluded that this recommendation had been met.

Recommendation 4

Recommendation with reference to Theme 3: Staff's competence:

The service is recommended to:
- introduce a competency assessment framework to satisfy themselves that training which has been delivered to staff is being applied in practice and resulting in positive outcomes for people.
- incorporate observational monitoring of practice and could, for example, include this in the supervision process.

This recommendation was made on 29 June 2015.

Action taken on previous recommendation

This recommendation is also reflected in the requirement made regards staff training.

Records and staff discussions showed that training was not up-to-date for many staff members and there was minimal evidence that staff's practice and competence were checked. There needs to be a more robust approach to the planning, recording and evaluation of training with ongoing monitoring of compliance. This recommendation is ongoing.

Recommendation 5

The following recommendation was made as a result of a complaints investigation:

The provider should ensure that residents' choices and night time routines, including rising in the mornings, are clearly documented in order to support decision making.

This recommendation was made on 20 October 2016.

Action taken on previous recommendation

On arrival in the home at 6am, there was only one person up who had been restless all night. Following the complaint about staff getting people up early, we found that management had addressed this with night staff, therefore we could see that staff were being compliant with this instruction.

We checked seven care plans for people who preferred to get up early in the morning. We found that these plans were still not being updated to reflect what time people preferred to get up. This had been previously pointed out to management, however, no progress had been made. This recommendation is ongoing.

Recommendation 6

The following recommendation was made as a result of a complaints investigation:

The provider should ensure that there is periodical management visits to the care home to monitor practice at night and early mornings.

This recommendation was made on 20 October 2016.

Action taken on previous recommendation

Night staff told us that the home manager had visited early one morning. The area manager had not yet visited the service overnight. This recommendation is ongoing.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Enforcement

No enforcement action has been taken against this care service since the last inspection.

Inspection and grading history

Date	Type	Gradings	
8 Dec 2016	Unannounced	Care and support Environment Staffing Management and leadership	Not assessed Not assessed Not assessed Not assessed
8 Dec 2016	Re-grade	Care and support Environment Staffing Management and leadership	Not assessed Not assessed Not assessed 2 - Weak
12 Jul 2016	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate
19 Nov 2015	Unannounced	Care and support Environment Staffing Management and leadership	Not assessed Not assessed Not assessed Not assessed
29 Jun 2015	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 4 - Good 3 - Adequate 4 - Good

Date	Type	Gradings	
9 Dec 2014	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 4 - Good 3 - Adequate 4 - Good
10 Jun 2014	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 4 - Good 3 - Adequate 4 - Good
25 Feb 2014	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 3 - Adequate Not assessed 3 - Adequate
4 Oct 2013	Unannounced	Care and support Environment Staffing Management and leadership	2 - Weak 2 - Weak Not assessed 2 - Weak
30 May 2013	Unannounced	Care and support Environment Staffing Management and leadership	2 - Weak 2 - Weak 2 - Weak 2 - Weak

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