Care service inspection report

Pentland Hill Nursing Home

Care Home Service Adults

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Edinburgh
EH12 7UB
Telephone: 0131 334 2383

Inspected by: Julie Tulloch

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Type of inspection: Unannounced

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Contents

Service provided by:

BUPA Care Homes (CFHCare) Limited

Service provider number:

SP2003002226

Care service number:

CS2003010660

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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	1	Unsatisfactory
Quality of Environment	2	Weak
Quality of Staffing	2	Weak
Quality of Management and Leadership	1	Unsatisfactory

What the service does well

The provider BUPA has continued to engage with the Care Inspectorate since the Improvement Notice was issued on 13 August 2013. BUPA senior management team have had a presence in the home while the home's management team review the systems and processes with a view to improving the outcomes for people who use the service.

BUPA senior management, quality department and the home's management team have continued to welcome daily discussions about our findings during the inspection visit. We note that these findings have been used to try to improve practice.

While we have seen some improvement, more work is needed to make further improvements. Work is needed to ensure where improvement is made it is carried out consistently and is sustained.

The provider has continued to accepted input from a number of professional advisors from the Care Inspectorate and specialist staff from the NHS in order to improve practice.

What the service could do better

This report describes the progress made in meeting the Improvements noted in the Improvement Notice dated 5 November 2013. We carried out an unannounced

inspection at the home between 2 December and 20 December 2013. We gave the findings of our inspection to the provider on 20 December 2013.

At this inspection we found some moderate improvements. We have extended the time the provider has to make the improvements. This will allow the provider to ensure staff have received the training that is planned and ensure learning from training is put into practice. We have extended the timescales of the Improvement Notice while we continue to support the home to make the required changes.

The extension of timescales Improvement Notice is dated 13 January 2014 and can be found on our website www.careinspectorate.com

What the service has done since the last inspection

Following the inspection in September 2013, the provider gave us an action plan telling us how they planned to make the improvements.

At this inspection, we found evidence of some positive progress and improvements in care for people who live at Pentland Hill. However we found that these progressive steps were inconsistently demonstrated over the five days of our inspection.
While we found some positive changes, these were not significant enough to meet the necessary improvements in outcomes for people at Pentland Hill Nursing Home.

The service has voluntarily suspended admissions to the home while they make the needed improvements.

Conclusion

Evidence from this inspection is that BUPA have made changes to how Pentland Hill is run and managed. We have seen some improvements but these have not been consistent or sustained and more improvements are needed to ensure all residents receive better care. As a result the Improvement Notice dated 5 November 2013 has not been met.
However, in recognition that the provider is taking steps to make the required improvements, we have extended the original timescales of the Improvement Notice to 28 February 2014 in relation to those areas of improvements where the timescales have now passed.
We will follow-up any progress with further inspection. We will also continue to work with relevant local authorities and with BUPA to support improvements that ensure residents' wellbeing is protected and promoted.

Who did this inspection

Julie Tulloch
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1 About the service we inspected

The Care Inspectorate regulates care services in Scotland. Prior to 1 April 2011, this function was carried out by the Care Commission. Information in relation to all care services is available on our website at www.careinspectorate.com.

The Care Inspectorate will award grades for services based on findings of inspections. Grades for this service may change after this inspection if we have to take enforcement action to make the service improve, or if we uphold or partially uphold a complaint that we investigate.
The history of grades which services have been awarded is available on our website. You can find the most up-to-date grades for this service by visiting our website, by calling us on 0845 600 9527 or visiting one of our offices.

Requirements and recommendations
If we are concerned about some aspect of a service, or think it could do more to improve its service, we may make a recommendation or requirement.
- A recommendation is a statement that sets out actions the care service provider should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.
- A requirement is a statement which sets out what is required of a care service to comply with the Public Services Reforms (Scotland) Act 2010 and Regulations or Orders made under the Act or a condition of registration. Where there are breaches of the Regulations, Orders or conditions, a requirement must be made. Requirements are legally enforceable at the discretion of the Inspectorate.

Pentland Hill Nursing Home (referred to in the report as 'the service') is owned and managed by BUPA (referred to in the report as "the provider") and is registered to provide a care service to a maximum of 120 older people (referred to as "residents" in the report). At the time of our inspection there were 81 people using the service.

The service is situated within a residential area of South West Edinburgh near to local amenities and public transport links. The building has gardens to the front and rear of the building.

The residents' accommodation is in two buildings. Each building has two floors accessed by a lift and stairs. In total there are four units accommodating up to 30 people within each unit. All rooms are for single use and all have en-suite toilets. Each unit has two communal lounges and a dining area within one of those lounges.

The service overall states that they aim to "provide our customers with the highest quality care service. We will use our health and care knowledge, specialist skills and values to deliver an individual service to our customers".

The home manager has overall responsibility for the management of the service. Each unit has a team of carers and registered nurses with varying degrees of skill, expertise and qualifications. The service aims to offer a home from which people would not need to move.

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

Quality of Care and Support - Grade 1 - Unsatisfactory
Quality of Environment - Grade 2 - Weak
Quality of Staffing - Grade 2 - Weak
Quality of Management and Leadership - Grade 1 - Unsatisfactory

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

We wrote this report after an inspection which commenced on the 2 December 2013 and concluded on 20 December 2013.
The focus of this inspection was to look at the progress in meeting the Improvement Notice dated 5 November 2013 and follow-up on any requirements from or since the last inspection where timescales had been reached.
We made the initial visit unannounced and spent five days in the home. We visited at various times of the day and evening. We gave feedback to the management team each day. Overall feedback was given to the provider on Friday 20 December 2013.

The inspection was carried out by Julie Tulloch Inspector, Rose Bradley Inspector, Saartje Drijver Complaint Inspector, Donna Gilmour Team Manager, Marjory Thomson Professional Adviser Nutrition, Joyce O'Hare Professional Adviser Tissue Viability , Alison Rees and David Marshall Professional Advisers, Pharmacy.

We met with the provider's representatives on Friday 20 December 2013 and gave feedback on progress with the Improvement Notice.

During this inspection we gathered evidence from various sources.

We spoke with:

- the manager,
- regional support manager,
- four clinical services managers,
- area manager,
- BUPA director of partnerships UK,
- BUPA director of partnerships North & Scotland,
- BUPA director of care and quality,
- two unit managers,
- staff nurses,
- carers,
- housekeeping staff,

- laundry staff,
- the handy man,
- the chef,
- catering assistants.

We spoke with residents and relatives as part of the inspection. We have used their views to inform our inspection. We issued 80 questionnaires as part of this inspection and received 30 responses. Twenty two were from relatives and 8 from residents. We have included these responses within this report.
We looked at a range of documents including:
Medicine Administration records (MAR) charts
Care plans and any accompanying documentation such as food and fluid charts and risk assessments
Menus
Nutrition and hydration policy
Cleaning policies and procedures
Infection control policies and procedures
Policies and procedures in relation to tissue viability and skin care
Staff training plans
Quality assurance documents and internal audits
Information from local authority reviews
Accidents and incidents.

We also looked at the environment and equipment and observed how staff cared for residents during the inspection visits. We carried out a number of mealtime observations as part of the inspection on all four units.

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 staff can demonstrate how they will meet residents' social needs which are recorded in their personal plans. This is in order to comply with SSI 2011/210 Regulation 5 - Personal plans. This also takes into account National Care Standards, Care Homes for Older People, Standard 17- Daily Life, Standard 6 - Support arrangement and Standard 8.1, Making choices. Timescale: 30 November 2013.

What the service did to meet the requirement

The timescale for this requirement has been reached. Please refer to quality statement 1.2 for progress on this requirement.

The requirement is: Not Met

The requirement

The provider must ensure the environment is safe and residents are protected. In order to achieve this the provider must:
(i) Ensure staff follow good infection control procedures by washing their own hands between caring for residents and offering all residents hand washing facilities before meals
(ii) Address the malodour in the units
(iii) Continue to remove unsafe, broken or damaged equipment from use
(iv) Ensure staff have enough pagers so that residents can call on available staff
(v) Ensure keys are available for staff and residents to open the locked bedroom doors within the home.

This is to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. SSI/2011/210 Regulations 4 (1)(a), 10(d) and 14. In making this requirement National Care Standards Care Homes for Older People Standard 4 Your environment.
Timescale:
(i), (iv), within 24 hours of receipt of this report.
(ii), (iii) and (v) by 28 November 2013

What the service did to meet the requirement

Some of the aspects of this requirement have been met. Some remain unmet. We have amended the wording of this requirement to reflect our findings at this inspection. Please refer to quality statement 2.2 for progress on this requirement.

The requirement is: Not Met

The requirement

The provider must ensure that all bedding in the home is fit for purpose. This is in order to comply with SSI 2011/210 4 (1)(a),14(b). This also takes into account National Care Standards Care Homes for Older People Standard 4 Your Environment.Timescale: To be completed by 28 November 2013.

What the service did to meet the requirement

We saw that new bedding was in place. We have reported this within quality of the environment statement 3 (2.3). We concluded this requirement is met.

The requirement is: Met - Within Timescales

The requirement

The provider must ensure that infection control procedures are in place and are followed at all times to ensure service users' well being. In order to achieve this the

provider must: a) review the systems for managing laundry safely to ensure they are consistent b) ensure all staff are aware of and follow infection control procedures; This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. SSI/2011/210 Regulation 4(1)d and takes account of the National Care Standards - Care Homes for Older People. Standard 4.3 Timescale: Before 28 November 2013

What the service did to meet the requirement

We have reported on this under quality of the environment statement 2 (2.2). We concluded this requirement is met.

The requirement is: Met - Within Timescales

The requirement

The provider must ensure that the home's garden is safe for residents to use. This is in order to comply with Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 10 - Fitness of premises (1) A provider must not use premises for the provision of a care service unless they are fit to be so used. And (2) Premises are not fit for the provision of a care service unless they - (a) are suitable for the purpose of achieving the aims and objectives of the care service as set out in the aims and objectives of the care service; and (b) are of sound construction and kept in a good state of repair externally and internally. This also takes account of the National Care Standards - Care Homes for Older People, Standard 4 - Your environment. Timescale: by the 28 November 2013.

What the service did to meet the requirement

We have reported on this under quality of the environment statement 3 (2.3). We concluded this requirement is met.

The requirement is: Met - Within Timescales

The requirement

The provider must adhere to the complaints procedure at all times. This is to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.SSI/2011/210/18 (3) Complaints. In making this requirement National Care Standards Care Homes for Older People Standard 5.1, 5.2 Management and staffing arrangements; 11.3 Expressing your views have been taken into account. Timescale: Within 24 hours of receipt of this report.

What the service did to meet the requirement

We have reported on this under quality of management and leadership statement 4 (4.4). We concluded this requirement is met.

The requirement is: Met - Within Timescales

The requirement

The provider must ensure that all required notifications are made to the Care Inspectorate. This is to comply with Regulations 19-24 of the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 2002/114) and section 53(6) of the Public Services Reform (Scotland) Act 2010. Timescale: To commence on receipt of this report.

What the service did to meet the requirement

We have reported on this under quality of management and leadership statement 4 (4.4). We concluded this requirement is met.

The requirement is: Met - Within Timescales

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

It is recommended that the provider continues to develop the participation strategy to ensure that methods are in place to enable all residents and relatives to assess the quality of the service including quality of care, quality of environment, quality of staffing and quality of management. All staff should continue to receive training in how to deliver the participation strategy. The strategy should be developed to take account of the cognitive abilities of all residents. This is in order to meet the National Care Standards, Care Homes for Older People, Standard 11- Expressing your views.

We have commented on this recommendation in Quality of Care and Support statement 1 of this report. We have made this recommendation again.

We made a recommendation about complaints during our regulatory work as follows;

Relevant staff should receive training to ensure that they are aware of the service provider's policies and procedures for handling complaints or requests for information from residents' representatives. This takes account of National Care Standards Care Homes for Older People Standard 5 and Standard 11.

We have discussed progress with the complaints work in quality of management and leadership statement 4 (4.4). We are satisfied the service has addressed this recommendation.

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.

We received a self assessment when we requested this from the provider prior to our May 2013 inspection. We did not request a self-assessment document prior to this inspection.

Taking the views of people using the care service into account

There were 81 residents in the home at the time of our inspection. We spoke with a number of residents in all four units. We took 40 questionnaires to the home for residents who wished to, to complete. We received 8 responses. Some of these had been completed by family members on their relatives behalf. We saw that in some cases a staff member had assisted the residents.

Taking carers' views into account

We issued 40 questionnaires to the service for relatives of residents at Pentland Hill. We received 22 responses. These reflected a range of views of the service. We have included some of these views throughout the report.

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: 1 - Unsatisfactory

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

At the previous inspections we found that the service performance was weak in relation to residents and carers participating in assessing and improving the quality of the care and support provided. We found this after looking at information about participation, how the home communicates and shares information with residents and relatives, minutes of meetings, reviews and questionnaires. The details of this can be found in the inspection report dated 3 July 2013.
The provider held two meetings for residents and relatives to give information about how they proposed to meet the findings of the September 2013 inspection on Tuesday 26 November 2013. These were attended by relatives and one resident.

The provider told us that regular resident and relative meetings were planned. We were told that feedback from the meetings would be shared via newsletters. Since the last inspection we saw that 'You said-We did' Noticeboards had been updated at the entrances of the units. These told visitors what had happened as a result of comments made about the service. We thought the service should look at how the same information was shared with residents who may not use the entrances.

We saw a document at the front entrance of each unit called 'Life at Pentland Hill Care Home- Our strategy for inclusion and participation'. This provided a statement of aims and objectives and how the service planned to consult with residents and relatives.

During the inspection we heard the manager consult with relatives about whether they would find it useful to have staff photographs and job titles in the unit.

We issued questionnaires for residents and received 8 responses. We saw that in some cases relatives had helped people complete these. Some had also been completed with the assistance of staff. The service should consider independent advocacy for residents who are unable to complete questionnaires but wish to do so.

The provider told us they had written to relatives and enclosed a Care Inspectorate questionnaire to give relatives the opportunity to be involved in the inspection process. We received 22 responses from relatives and have used these to help form our assessment of the service. We have noted responses throughout the report.

As part of the inspection we asked the provider to tell us how they are going to meet the Improvement Notice and requirements we have made. In the action plan submitted to us, by the management team told us they have been working on ways to ensure that residents and relatives are consulted about the service. They told us some consultation had already taken place with residents and relatives about destination areas within the units. Destination areas are areas of interest where residents who like to walk can stop, rest and look at things which may be of interest to them. We were told this has included residents with a cognitive impairment through the use of pictures. The destination areas have not yet been created and we look forward to seeing the results of this work.

Areas for improvement

We did not fully inspect this quality statement during this inspection as the purpose of this inspection was to follow-up on the Improvement Notice. However we have considered our findings in general with regard to participation. In the action plan, the previous manager told us she planned to send an updated participation strategy to all residents and relatives. The previous manager also said a ' themed focus area' had been issued to all staff about participation and that she planned to explore staff understanding of this at supervision. This work was at an early stage at the last inspection. Since then the manager has changed. The new manager and new regional manager had plans to further progress this work. This included reiterating to staff their responsibilities, in areas such as participation, through supervision at the beginning of 2014.

We were encouraged by the plans to improve participation and the work that has started. We hope to see this work start to make a positive change in outcomes for the residents of Pentland Hill Nursing Home. See recommendation 1.

Grade awarded for this statement: 2 - Weak

Number of requirements: 0

Number of recommendations: 1

Recommendations

1. It is recommended that the provider continues to develop the participation strategy to ensure that methods are in place to enable all residents and relatives to assess the quality of the service including quality of care, quality of environment, quality of staffing and quality of management. All staff should continue to receive training in how to deliver the participation strategy. The strategy should be developed to take account of the cognitive abilities of all residents. This is in order to meet the National Care Standards, Care Homes for Older People, Standard 11- Expressing your views.

Statement 2

We enable service users to make individual choices and ensure that every service user can be supported to achieve their potential.

Service strengths

Recreation, social and community activities and personal development are essential to quality of life for people of all ages. These activities benefit health and well-being and support people to achieve their potential, even when they are frail. Suitable activities should be available for people who have differing levels of dementia.
At the last inspections, we found that the performance of the service was unsatisfactory in enabling residents to make individual choices and supporting them to achieve their potential. The details of this can be found in the inspection reports dated 3 July 2013 and 11 October 2013.
At this inspection we saw new activity coordinators had been recruited and were being inducted to the home.
We saw that some activities were taking place during the five days of our inspection. We spoke with the activity coordinators who were keen and enthusiastic about their roles.

A new schedule of activities was being prepared for 2014.

Comments made to us about activities from our questionnaires included:
'Changes are taking place slowly',
'Finally activities appear to be being addressed for people with dementia',
'My (relative) just gets left sitting in front of the television',
'Not as frequent at present but hopefully this will improve with the new staff and better weather'.

Areas for improvement

We have considered our findings in general with regard to residents being helped to make individual choices and being supported to achieve their potential. We have considered choices with meals, choices about residents accessing their bedrooms, choices about access to the garden and choices about activity. We found some evidence of improvement in this area with positive outcomes for some residents. The planned work should lead to better outcomes for more residents when fully implemented.
We made a requirement at the last inspection as follows: '' The provider must ensure that staff can demonstrate how they will meet residents' social needs which are recorded in their personal plans.''

Work was planned to improve personal plans and social activity provision by the use of information from 'My Life' folders. We will follow up how the service uses the information from this work to help them produce individual and organise group activities, social experiences and keeping people in touch with their local community. We have concluded that although some plans were in place, work is at an early stage of implementation for some residents and has not yet started for others. We have made this requirement again. See requirement 1.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 1

Number of recommendations: 0

Requirements

1. The provider must ensure that staff can demonstrate how they will meet residents' social needs which are recorded in their personal plans.
   This is in order to comply with SSI 2011/210 Regulation 5 - Personal plans. This also takes into account National Care Standards, Care Homes for Older People, Standard 17- Daily Life, Standard 6 - Support arrangement and Standard 8.1, Making choices
   Timescales: By 28 February 2014.

Statement 3

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

Service strengths

At the last inspections, we found that the performance of the service was unsatisfactory in ensuring that service users' health and wellbeing needs are met. The details of this can be found in the inspection reports dated 3 July 2013 and 11 October 2013 and the Improvement Notices dated 13 August 2013 and 5 November 2013.

Following our last inspection our inspectors and professional advisers continue to assist the home to make improvements in the inspection of the medication systems, food, fluid and nutritional care and tissue viability. We have reported on some positive changes on each aspect of the Improvement Notice below. The areas for development section describes and evaluates our findings and reports on what the service still need to do to improve care.

Areas for improvement

Our Professional Adviser (Tissue Viability), followed up on the changes the service were making to pressure area care. Focusing on tissue viability has allowed us to make a comprehensive assessment of the different improvements which are part of the Improvement Notice. We have been able to look at the service performance in the following areas:

- residents' health and wellbeing needs,
- staff training,
- monitoring of staff practice,
- management and leadership and quality assurance,
- care plans.

Findings from our, Professional Adviser (Tissue Viability), are o outlined below. We have used the evidence from this to assess the services performance toward meeting the Improvement Notice.

Care plans for pressure ulcer prevention

We examined seven residents' care plans in detail who had wounds or were at high risk of developing pressure ulcers. All of these residents had a recent Waterlow score calculated as part of their monthly review, which indicated their level of risk. We noted that one resident's score was inaccurate, although this did not affect their level of risk. We also noted that staff were still not recording the full date on these assessments which was raised as an issue at the last inspection.

We saw from the seven plans that all these residents had a plan of care in place for pressure ulcer prevention. These care plans contained relevant information about pressure ulcer prevention, such as frequency of skin checks, re-positioning timescales and the pressure reducing equipment in use but we found that there was a tendency for staff to include information which overlapped with other care plans such as nutrition, mobility and continence which then made these plans unwieldy, repetitive and difficult to follow.

We also observed that the care plans recorded details about the pressure reducing equipment in use with information about the settings of active mattresses and seat cushions to promote optimum pressure reduction for residents when sitting up or lying down. We examined the settings of the active equipment and in all instances

this corresponded with the information recorded in the care plans. This was an improvement from the last inspection.

We were concerned that amendments to treatments eg antibiotics and dressings were not always reflected in the care plans and that where staff did amend the information this was not dated or signed as per Nursing and Midwifery Council guidance on record keeping.

Information about prescribed creams and topical application were also part of the care plans for pressure ulcer prevention and skin care. We again noted that there was no specific detail about the areas for application or frequency of applying the creams. This was discussed with staff following the last inspection. There was an inconsistent approach between the 4 units towards implementing the topical MAR charts (TMAR) which would assist with this. More work was needed to improve the system and ensure there is a consistent approach to the use of topical products.

Repositioning charts were examined and we found that turning regime timescales generally matched those recorded in the care plans.

Wound assessment and management

We observed that the initial and on-going wound assessment charts were used well and the information recorded was clear about the wound assessment process and how wounds were progressing. Wound care plans, however contained too much detail about other areas of care and did not always cover the key points of wound care. For example, two care plans did not have any information about how the wound was to be cleansed and where dressings were changed to another product, this was not always dated and signed or a rationale given for this change.

We saw instances where skin tears were being treated with a short-term care plan and also had a wound care plan which contained exactly the same details for care and treatment. This type of duplication is not necessary.

Wound photography was still being used and although recent photographs were of better quality, there were photographs we saw on the day of the inspection which were not of good enough quality to provide a meaningful record of progress. We discussed with BUPA management team that a good practice guide for staff in wound photography should be developed. We also discussed that the policy on consent for photography should be reviewed to ensure informed consent was given.

We noted that six residents had minor wounds or skin tears. There was no evidence in the management of these trauma wounds that staff had referred to BUPA policy guidance. For residents who had skin which was liable to have skin tears or who had repeated occurrences of skin trauma, we expect that this information would form part of a preventative approach. We did not see any information documented in care plans to reflect this.

Use of pressure reducing equipment

The manager was able to evidence that a mattress audit had been carried out since the last inspections. Staff in all four units had tested the mattresses and covers to determine if they were fit for purpose. Mattresses which did not pass these tests had been disposed of and new mattresses had been purchased and were in place.
Active mattresses had also been reviewed and replaced where necessary. We saw that all residents with pressure ulcers or who were at high or very high risk of developing these were being cared for on these active mattresses. Some active mattresses require a base mattress. The manager was advised to liaise further with the manufacturer to be clear about which of these mattresses require a base mattress underneath.
All other residents had pressure reducing foam mattresses as standard on their beds. This is good practice to meet pressure area care as well as comfort needs of older people.

Mattresses and seat cushions examined on the day were found to be clean and in a good state of repair. Cleaning of the pressure reducing foam mattresses had been initiated and was being recorded on a checklist sheet. There was no record of these being turned on a monthly basis as per the manufacturer's recommendation to ensure even wear and prolong the mattress lifespan. This was discussed and the manager agreed to look at ways to improve this.

We concluded that there had been improvements in the provision of pressure relieving equipment and some progress in the management of wounds, however more work was needed to ensure a consistent approach to the management of wounds, use of pressure relieving equipment and care planning.

We have used the above findings to consider Quality of Care and Support, Quality of Environment Quality of Staffing and Quality of Management.

Medication

Both Care Inspectorate Pharmacy Advisers carried out part of the inspection in relation to medication. This was to follow up on the medication elements of the Improvement Notice. The progress in meeting these is detailed below.

1. Medication
(A) By 28 November 2013, you must put in place a system to ensure that:

a) medication is administered as prescribed; this must include administering the preparation as prescribed and following any specific instructions when a covert medication pathway is prescribed. In any circumstances when medication is not given as prescribed, the reason for this must be clearly recorded.

Progress
It is important to have an accurate, up-to-date record of how medicines have been managed by a service as this can reduce the occurrence of poor care. The medication administration records in the care home were pre-printed MAR (Medicine Administration Recording) charts supplied by the community pharmacist and filled in by the home. The MAR charts are a record of how the service has managed medication for the resident. Repeat medication was supplied to the care home with the MAR on a 28 day cycle. We sampled MAR charts from the current cycle of medication for 31 residents and from the last completed 28 day cycle of medication for 13 of the residents.

We saw a general improvement in the administration and recording of medication since our last visit in September. Medicines were generally given as prescribed and we noted a tightening up of the audit trail of medicines. However, despite this we still saw some practice which caused us concern, for example:

- medicines not given as prescribed, such as pain medicine, medicine for glucoma and dementia,
- medicines recorded as out of stock, sometimes recorded as out of stock in the morning but then given at night.

We continued to find antibiotics prescribed three times a day but not given at regular intervals throughout the day, and a medicine used in the management of osteoporosis given at the same time as mineral supplements despite guidance to the contrary.

The service audits of medicines had picked up some gaps in the administration of regular medicines. However, gaps in the audit trail of medicines carried forward from previous cycle/received this cycle do not allow staff to always determine if the medicine was given or not. We also noted a monitoring sheet for use with a patch containing a strong pain-killer, which should be given every three days, where the monitoring sheet was not used daily to ensure the patch remained in place.

We noted that the MAR charts contained a number of duplicate entries and entries for products that appear to be no longer in use. We advised the home to liaise with their supplying pharmacy to rectify this so that the MAR only contains current items.

We looked at the care of one resident who received medicines covertly. We discussed our findings with the manager and have asked that she reviews the policies and procedures which guide staff practice in the home. We have directed the manager to the best practice guidance from the Mental Welfare Commission to help with this review.

We had concerns about the arrangements in place to ensure one resident received their medicines properly. The MAR charts indicated this resident should receive some of their medicines at night via a Percutaneous Endoscopic Gastrostomy (PEG) tube, i.e. passed into the stomach through the abdominal wall via a tube. Information from a pharmacist on how to do this properly for each medicine was kept separately in the office and was not available for agency staff in order to administer the medicines in accordance with the instructions. Overall there has been progress in this area but more and sustainable progress is needed.

b) the Medication Administration Records are signed each time medication is given.

c) enough medicine is available for service users to receive medication as prescribed.

Progress
These are discussed above. Despite progress in this area, we still noted examples where medicines were not available when required.

d) ''as required'' medicine instructions are clear for staff to follow, detailing the reason for administration, the maximum dose and minimum time between doses;

Progress
At our visit in September we found the care plans for use of "when required" medicines contained reasons for administration that were often generic and lacking any meaningful detail. We did not see any progress at this visit.

e) appropriate arrangements are in place for securing the medicine trolley for safe storage of medicines.
Progress

Progress
We found medicine trolleys securely stored.

f) there is a safe method of recording and storage of medicines for return to pharmacy.

Progress
We found that medicines for return to the pharmacy were securely stored and recorded.
However, we also noted that the next cycle of medicines recently received into the home from the pharmacy were not stored securely.

Overall we found some progress toward meeting the medication part of the Improvement Notice. We have extended the timescales to allow the provider to make further improvements.

Food/Fluids and Nutritional Care

The Professional Adviser (Nutrition) assisted with the inspection of food, fluids and nutritional care. This was to follow-up on this element of the improvement notice. The progress in meeting this element is detailed below.

2. Food/Fluids and Nutritional Care

By 28 November 2013, you must put in place a system to:

a) accurately calculate and record the Body Mass Index of service users according to assessed need;
b) ensure that where there is identified weight loss, the Malnutrition Universal Screening Tool (MUST) guidance is followed, including weighing individuals according to need;
c) review, record your findings and update each care plan as so required to ensure that each service user who needs assistance to eat, drink or maintain their nutritional status has a care plan that describes the specific interventions for that individual;
d) ensure that all service users receive support at mealtimes to meet their assessed needs;
e) ensure service users dietary and fluid likes and dislikes are recorded and these are used to help identify meal preferences for any service user who may be unable to indicate or verbally express choices;
f) ensure that food and fluid charts are completed for those service users who require them;
g) ensure that the content of food, fluid and weight charts are evaluated and the information is used to plan care;

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

Progress
Management advised us that all the registered nurses have received training and supervision about the BUPA "MUST" nutritional screening tool ''a self-learning pack" . The training included calculating body mass index (BMI) to ensure staff were updated in the procedure.

The Malnutrition Universal Screening Tool (MUST) is the best practice screening tool which assesses residents risk of undernutrition as no risk, medium risk or high risk.

We found all service users were weighed at least monthly and their BMI calculated. Those service users identified as at nutritional risk were weighed weekly. To ensure

accuracy staff said large gains or losses in weight were rechecked. However we found the process used to weigh service users was not consistent between staff or between units. After discussion with our Professional Adviser (Nutrition), the management addressed this during the inspection by producing a procedure for staff to measure heights and weights. Staff had still to receive training in this procedure.

When we spoke with management we found that they had a new procedure for the management of undernutrition. We found staff could describe some of the expected actions of this to us. We found this procedure was not written down and encouraged management to do so, which they did. This means staff should now have consistent guidance to which they can refer. We concluded that the procedure needs to be further expanded to ensure it is comprehensive and includes information such as the management of fortified diets and how the service are using newly introduced snack pots.

A fortified diet aims to give a resident more calories. This is often done by adding extra butter, cream and skimmed milk powder. We were advised that all fortification was carried out when food was prepared in the kitchen. We found the new system was complex. Residents with a medium risk MUST score should have their meal fortified twice, for example with cream and butter. A resident with a high risk MUST score should have their meal fortified three times, for example with cream, butter and then honey on a chop or vegetables. However,this system did not take into account the residents' preferences or whether the dish remained palatable. In addition, some dishes on the menu were not appropriate for fortification and residents could not receive extra calories.

Some improvements the service should make to fortified diets are detailed here.

- Fortified diets need to be personalised and made appropriate for each resident. This should include a review of their usual waking, sleeping, eating pattern to see when the resident would eat best.
- Food preferences should be checked to establish individual tastes and suitability of the menu.
- Information about individual preferences should be used to set targets for fortified milk.
- Where appropriate use double cream instead of whipping.
- Use standard recipes to establish nutritional content.
- Offer butter instead of a lower fat spread.
- Offer milk to drink at lunchtime
- Cease using 'no added sugar' squash for those residents who need extra calories.

Our observations show that the system for fortified diets is complex and not always working in practice in order to achieve the weight gain for the residents that we expect.

Positively, we found that:

- all eating and drinking care plans have been reviewed since our last inspection
- a prompts and actions check list was used by staff to try to help them identify resident's needs
- nutrition was included in guidance issued to staff about how to complete monthly care plan reviews
- the chef spoke with residents, who had unplanned weight loss, to establish what snack foods they would like each day to boost their calorie intake, with snack bowls provided each afternoon with food that residents liked, such as crisps, mini chocolate bars and grapes
- in one unit we found that assessment of ongoing weight loss had resulted in a resident being given a plate guard to help them eat; while this was a positive step we found that residents assessed as needing equipment did not receive this consistently at each meal
- some residents on a fortified diet and not gaining weight also received nutritional supplements, more work needs to be done to improve fortified diets as we described above
- the manager has put extra hours into the catering department to facilitate meeting service user special dietary needs.

When we looked at food and fluid intake charts we found that in Allermuir there was an improvement in these charts. We observed a more organised approach with the host completing the charts with the help of the staff who assisted the resident or took their plate away. This record keeping was being done near to the time the food and fluid was consumed which is good practice. However, we did not see this level of improvement at all times during our observations in other units.
We reviewed a sample of care plans and found the description of the care to be given to the residents had improved overall, although further improvement was needed.

- All of the care plans we reviewed stated 'fortified diet'. This was not person-centred. In order to increase calories a care plan should include a review of residents usual waking, sleeping, eating pattern to see when the resident would eat best. Food preferences should be checked and recorded to establish individual tastes.

Some further work had been done to establish residents' eating and drinking likes and dislikes and this was shared with the catering staff. We thought that this was not

detailed enough and further improvements would benefit all residents. When we explained this to a nurse in charge in one unit we found a positive response to our comments. During the inspection the nurse began asking individual residents about each dish on the menu. She told us this had provided her with more detailed information about likes and dislikes. We found that, based on this information, she had requested food that residents enjoyed from the kitchen.

- The new practice of offering high calorie snacks should be included in the care plan of the residents receiving these.
- Eating and drinking interventions should be grouped together in like topics so, for example, all the information about assisting a resident to eat and drink is held together and is not scattered throughout the care plan.
- Routine family assistance and support should be included and described in the care plan because this forms an important part of some residents' overall care.
- The care plans we saw showed that staff were calculating service users fluid requirement using 30 mls per kg body. This is correct for the majority of service users but best practice guidance states that the calculation of 30 mls per kg does not apply for the very underweight or overweight. A minimum fluid intake of 1500mls/1600mls should apply to underweight service users unless there are underlying conditions. This means the fluid target of service users with a very low body weight was set too low but we did observe that most were exceeding this low-level.
- Since the last inspection we saw staff were noting daily fluid intake. The service needs to progress and develop the evaluation of this to establish whether residents had or had not met their fluid target and plan what steps should be taken as a result of this.
- More work needs to take place to evaluate the information from food intake charts and the action to be taken as a result of the findings. In some care plans there was no evaluation of the residents food intake documented. In one evaluation of a plan we found one person's intake was described as poor but the steps to be taken as a result of this were not mentioned.
- In the plans we reviewed there was a lack of reflection on why residents with a care plan specifying a fortified diet or a fortified diet and also receiving prescribed nutritional supplements were not gaining weight.

When we observed mealtimes and the support that residents received we found that:

- there was a host in all four units who helped to manage mealtimes
- there were more staff in the dining room to assist with mealtimes than at the last two inspections of the home

- there was a general improvement in the level of support residents received at mealtimes, although this was not consistent throughout the five days of the inspection across all four units
- some units had a calmer atmosphere at mealtimes but this varied between mealtimes and units.

To further improve the service should:

- ensure use of best practice to instruct staff about how they should support residents to eat and drink.
- agree how meal and snack times are managed and coordinated.

We observed some examples of good practice and interactions when staff assisted residents at mealtimes. However we also saw some examples of poor practice when staff helped people too quickly, did not help for the whole meal or did not speak with the resident during their meal.

In conclusion we thought that some of these difficulties could be addressed by agreeing and putting into practice an operational procedure for the management of mealtimes and snacks. This should explain how staff ensure residents dietary needs are met and they have an enjoyable experience. It should also consider how other activities fit with mealtimes such as medication administration and staff mealtimes.

Overall we found that, whilst the provider was making improvements these improvements, had not led to better outcomes for all of the residents. We concluded that some of the elements of the Improvement Notice for food, fluid and nutrition were not met and we have extended the timescales for the provider to make further improvement.

3. Training

(A) By 18 September 2013, you must develop a staff training programme with dates for implementation for:
a) management and leadership, for staff in such roles, who are involved in the provision of the care service;
b) prevention and management of pressure ulcers, including best practice guidance for tissue viability;
c) the calculation of Body Mass Index and use of the MaInutrition Universal Screening Tool (MUST);
d) food, fluids and nutritional care;
e) creating a positive mealtime experience taking account of best practice documents such as, NHS Scotland (2002) Nutrition for physically frail older people best practice statement, and providing assistance with

eating and drinking;
f) person-centred care taking account of best practice documents such as, Scottish Executive (2006) Delivering Care, Enabling Health, and the development of appropriate care planning;
g) the safe administration of medication;
h) calling for medical assistance in the event of resident illness or injury;
i) caring for people living with dementia;
j) moving and handling;
k) hand hygiene.

(B) By 25 September 2013, you must provide a copy of the above training programme to the Care Inspectorate.

(C) By 28 February 2014, you must provide written confirmation to the Care Inspectorate that all identified training has been completed.

This is in order to comply with the Social Care Social Work Improvement Scotland (Requirements for Care Services) Regulations 201 1 ,SSI/201 1/210 regulation 4(1)(a) and regulation 15(b)(i) Staff training.
Progress
The home manager had sent us a copy of the training plan as set out in (B) above by the timescale.The proposed training programme includes plans for training in all of the above topics identified in (A) above for certain staff.
For example, there were 129 staff currently employed in the home. All 129 have been identified to receive training in hand hygiene, person-centred care and mealtimes. Training is planned for registered nurses only in care planning, care records and accountability.
We have made some comments on how to improve the proposed training in medicines, food, fluid and nutritional care and tissue viability to the provider. The timescales for completion of training had not yet been reached. We will monitor how the outcomes for residents in the home is affected by the implementation of this training.
The service has met the aspects of the training part of the Improvement Notice where the timescales have been reached.

4. Monitoring staff practice

By 28 November 2013, you must:

(A) put a system in place to audit and monitor staff practice and competency to ensure that you are making proper provision for the health and welfare needs of service users and to protect them from
avoidable risk of harm.
(B) ensure this system must make provision for, but not be limited to:
a. care planning, reviews and other accompanying documentation

b. safe storage of medicines and medicines administration
c. food, fluid and nutrition and the mealtime experience
d. pressure area care
e. calling for medical assistance in the event of resident illness or injury.
f. moving and handling
g. management and leadership
h. hand hygiene
i. staff supervision and clinical observation of practice

(C) ensure you have a system to record where you identify any unsatisfactory practices, including the action to be taken to effectively remedy any such practices.

(D) carry out a review of staffing, including skill mix and deployment of staff, to ensure that you make proper provision for the health and welfare needs of service users and provide a copy of the review to the Care Inspectorate.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 201 1(SSI 201 1/210), regulation 4(1)(a) and 15 (a).
Progress
We have used the information from our observations of care, looking at medication management, incident forms, food, fluid and nutritional care, pressure area care, care records and supervision records to assess the home's performance in this element of the Improvement Notice. We have also used information from discussion with staff and management and responses to our questionnaires from residents and relatives. At the previous inspection in September 2013 we discussed with the provider their review of staffing.We gave clear examples of our observations of care and why we did not think the home was adequately staffed. We saw improvement in this area, but found the following examples which still need to be addressed;

- there is a need for extra staff in units where residents have dementia and are unable to use a call-bell or wait for assistance
- residents who need full assistance and are assisted by different staff throughout their meal
- residents with a high level of need in one unit
- lack of activities and social interaction
- the nature of incidents and accidents notified to us.

At the September 2013 inspection we found that the service had taken positive action to lay down firm foundations which should improve monitoring of staff practice. For example, a number of systems and processes have been started such as clinical risk meetings, competency assessments and staff support and supervision meetings.

During this inspection we saw a good example of how these systems and processes were working. We found there was satisfactory management and oversight of a medication issue, and through our notification system we can see that errors in medication administration are being spotted by management and responded to appropriately.
During this inspection we found that there remained care practices in medicines management, food, fluid and nutritional care, pressure area care, moving and handling, hand hygiene, staff supervision, care planning, which although improving did not meet all of the residents needs. We have concluded that although the systems used to monitor staff practice are improving, they are not yet adequate to consistently improve the outcomes for some residents.
This element of the Improvement Notice is not met. We have extended the timescales of this part of the Improvement Notice to 28 February 2014.

5. Management and Leadership and Quality Assurance

By 28 December 2013, you must put in place a system to ensure that
a) management and leadership practices are checked on a regular basis by a suitably qualified and competent person not involved in the day to day operation of the care service. Checks should be recorded and
reported to the provider;
b) where you identify any unsatisfactory practices, you keep a record and effectively remedy these;
c) problems identified through any quality assurance audits are rectified.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 201 1/210), regulation 4(1)(a)
Progress
We used information from discussion with the BUPA management and quality assurance team to evidence this part of the Improvement Notice. We also looked at incident records, management of medicines and quality assurance documents and records.
We concluded that there was a clear plan for oversight of the home by the quality team within BUPA, who are external to the home. Plans were in place for an assessment and report completed by the quality team, which would evaluate the management and leadership practices of the home. This report would be sent to the operations team area directors to action areas where improvements needed to be made. This was a new reporting system starting on 1 October 2013.

The provider has given us a leadership and management plan which outlines a range of measures which they plan to use to keep oversight of day to day practice within the home.

There is evidence of strengthening management and leadership under the stewardship of the new manager. Relatives we spoke with told us they felt the manager was aware of the weaknesses of the service and were confident that she was committed to strengthening and improving the service. All of the residents we spoke with knew the manager and had spoken with her.

Although the service has worked had to put into place a system, this system was not fully operational. Our evidence from the inspection was that we continued to identify areas of poor practice which should have been picked up from an effective quality assurance system. Overall we concluded the management and leadership of the home was improving.

At this inspection we heard that the personnel who had been brought in to support the home from other homes would be leaving the home as the new staff came into post. The provider told us there was a planned transition for this. We thought this was a sensible decision so that all of the key staff did not change at once.

Some of the key staff included clinical service managers who had been acting as unit managers in a supernumerary status. This means they were additional to the staffing numbers in the home. The four unit managers oversee the running and care delivery in each unit. They also act as a role model for staff and ensure training is put into practice.This work is essential to improving outcomes for residents. At feedback we told the provider that we thought the unit managers post needed to be supernumerary to make the necessary improvements in the home. The provider has agreed to keep this post supernumerary and will formalise this agreement through a variation process.
We concluded that this element of the Improvement Notice is not met. We have extended the timescales of this part of the Improvement Notice to 28 February 2014.

6. Care Plans

By 28 November 2013, you must put in place a system to:
(A) ensure that all service users' personal plans (care plans) and other necessary, accompanying documentation including relevant risk assessments are reviewed and updated to include a full assessment
of the health and welfare needs of each individual service user together with details of how these are to be met, including all aspects of physical and mental health. This must include but is not restricted
to:
a. medication
b. nutrition
c. tissue viability including use of pressure reducing aids and take
d. account of sitting for long periods
e. moving and handling
f. information from accidents and incidents

g. guidance from health care professionals
h. mental health stress and distress
i. oral hygiene
j. hand hygiene.
(B) ensure that care plans accurately reflect the outcome of any
(C) assessment and that where risks are identified, appropriate risk, reduction measures are in place;
(D) ensure care plans are regularly and comprehensively evaluated to meet individual need;
(E) ensure care plans are reviewed with the resident and their representative(s) at least once in every six month period.
(F) ensure care plans contain sufficient information to inform staff of the
(G) correct equipment to be used and assistance required in all areas of assessed need;
This is in order to comply with the Social Care Social Work Improvement Scotland (Requirements for Care Services) Regulations 201 1, SSI/2011/210 regulation 4(1)(a) and regulation 5(a)(b)(c)(d).
Progress
The timescale for the service to achieve this element of the Improvement Notice was 28 November 2013.

We looked at a sample of 8 care plans in detail as well as a number of other care plans specifically in relation to the particular elements of the improvement notice such as medication, nutrition and tissue viability.

When we spoke with staff we were aware that the care plan documents were quite new and staff were still becoming familiar with them.

Overall we found that some plans contained vast information about conditions or illnesses. We found this to be general information which had not been personalised or individualised. Therefore the care plan did not guide staff as to how to meet an individuals needs in the way that was in keeping with their wishes and lifestyle.

We found there were recording issues that needed to be addressed. For example:

- some entries were not signed or dated
- some entries were partially written and vital information had not been recorded
- some of the language used within the entries made the meaning unclear
- duplicate copies of forms in records
- care plans not being updated with information from assessment or reviews
- when reviews meetings are held no record of the content of the discussion that has taken place with the resident or their representative, this would inform the care plan

- instructions from external professionals not being used to update the plan of care
- lack of recording of the effectiveness of interventions such as medication, nutrition and general care
- lack of evaluation of care and changing the care plans based on a comprehensive evaluation.

We found there were contradictory entries in some plans about how residents moved around. This may lead to staff who are not familiar with the resident assisting them in the wrong way for example by assisting a resident to walk when they need to use equipment. We were aware that this has happened.

We concluded that work had started to improve the care plans but there was still work to do and the improvement notice was not met. From the training plan we had been given we saw that training in charts, daily life recording, planning, evaluating and person-centred care planning was planned to take place in January 2014. We would anticipate that once staff have received this training they would start to implement the learning and we would see improvements in how care is recorded and delivered. We have extended the timescale of this element of the Improvement Notice to 28 February 2014.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 0

Number of recommendations: 0

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 2 - Weak

Statement 1

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

Service strengths

We concluded that there was little change in the findings of this quality statement since the previous inspection. We graded the service as weak for this quality statement.
The service's methods of participation described in quality theme 1 statement 1 (1.1) also apply to this quality statement and have contributed to the findings of the assessment of the quality of the environment.

Areas for improvement

We recognise the service has focused on addressing the issues within the Improvement Notice.
We observed the environment had not changed significantly since our inspection in May 2013.
We concluded that the environment could be improved for residents. We found little evidence that staff were using information gained from observing residents' habits or behaviours or from their understanding about residents' conditions to make adjustments or improvements to the environment. Work was planned but has not been completed. For example there was planned work to provide points of interest in the units. The service called these destination areas. In their action plan the provider said they have been consulting residents about the destination areas and including residents with communication difficulties through the use of pictures. Progressing with this work could provide beneficial outcomes for residents.

Grade awarded for this statement: 2 - Weak

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

At this inspection we saw some positive action had been taken to address and improve issues we raised which potentially compromised residents safety.

For example, when we checked a sample of residents' rooms where bedrails were used we found that the issue where only one bedrail was fitted had been corrected. We did not find any residents in bed where the brakes on their beds had not been applied. We had asked the service to rectify this on the day of the last inspection and did not find any further examples of this practice during this inspection.

At previous inspections we made a requirement as follows:
The provider must ensure the environment is safe and residents are protected. In order to achieve this the provider must:
(i) Ensure staff follow good infection control procedures by washing their own hands between caring for residents and offering all residents hand washing facilities before meals
(ii) Address the malodour in the units
(iii) Continue to remove unsafe, broken or damaged equipment from use
(iv) Ensure staff have enough pagers so that residents can call on available staff
(v) Ensure keys are available for staff and residents to open the locked bedroom doors within the home
(vi) Ensure kitchen checks are carried out and food is stored correctly
(vii) Ensure when assessed as needed bedrails are used appropriately to ensure residents safety

This is to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. SSI/2011/210 Regulations 4 (1)(a), 10(d) and 14. In making this requirement National Care Standards Care Homes for Older People Standard 4 Your environment.
Timescale:
(i), (iv), (vi)and (vii) within 24 hours of receipt of this report.
(ii), (iii) and (v) by 28 November 2013.

We continued to see further progress toward meeting this requirement during this inspection. We found that:

- in Carnethy the cafe remained free of broken equipment
- similarly, the quiet lounge on Caerketton was a space that residents could use
- a permanent and appropriate repair had been made in the bedroom with the leaking soil pipe
- some broken furniture and stained chairs had been removed

- some residents on one unit were offered wipes before and after some meals
- uncovered plated meals were not left out in the kitchen
- action had been taken by the manager to ensure cleaning measures were in keeping with BUPA policies and procedures and cleaning was effective
- floor coverings had been removed and replaced, improving the malodour in all four units.

On one occassion we found curling tongs and a hair dryer plugged in. These were in a communal area and were hazardous. We asked that this be rectified immediately on the day of the inspection and this was done.
The outstanding parts of this requirement are described in areas for development below.

We followed up on a requirement made as a result of a complaint investigation as follows:

The provider must ensure that infection control procedures are in place and are followed at all times to ensure service users' well being.
In order to achieve this the provider must:
a) review the systems for managing laundry safely to ensure they are consistent
b) ensure all staff are aware of and follow infection control procedures.

This requirement was made because laundry labelling systems were unclear.
During this inspection we found that there was still conflicting information on display in the sluices as had been found during the complaint and when we initially followed up this requirement. We discussed this with the manager during this inspection. As a result of this discussion the old notices were removed and new laundry labelling notices were put into all the sluices. This means that staff will have clear guidance to follow to ensure they comply with infection control procedures. We have concluded that this requirement has been met.

Areas for improvement

There are outstanding parts of the requirement we made about the environment which remained not met, as follows:

- handwashing had improved but was still not consistently offered to all residents before meals
- there was malodour in some areas of the home
- in Turnhouse the sitting/dining room was still uncomfortably hot at times
- some of the seat cushions were missing from the armchairs.

In the action plan sent to us by the provider we were told that regular walk-around audits were carried out by the senior management team and any broken equipment would be removed from use. During our inspection we highlighted some broken

equipment which had not been disposed of. We were encouraged that the manager responded immediately and removed the broken items. However we concluded that the management walk-around system to address this problem was not yet fully effective.
When residents use a call bell there is no audible alert. Staff carry pagers which tell them who needs help and their location. At previous inspections we found a lack of pagers. This meant that there was an increased risk that residents who called for assistance had a delay before staff could respond to them. The manager told us that more pagers had been purchased. Despite this action we found there were still not enough pagers for all available staff to have one and the number of pagers available varied during our inspection. While the home is not at full occupancy the impact of a lack of pagers is reduced. The provider needs to ensure that there are enough pagers to enable staff to respond to residents in good time. The manager has agreed to review pager numbers on an ongoing basis to ensure there are enough on each unit.

Bedroom doors continued to be locked in some units when residents were not using them. The providers' action plan told us that residents and relatives were sent letters to ensure that any resident who wished a key to their room, had one provided. We were told that there were a few locks that required to be changed as a result of this consultation and this work had not yet been completed. It was still difficult for us to find out who had a key to rooms where residents had not requested a key or could not use a key independently. We concluded that residents and families continued to need an easy way to know who can help them access their room when they wish it.

The requirement we made at the last inspection has been amended to reflect the findings of this inspection. Some aspects have been met and some progress has been made toward meeting the other aspects. See requirement 1.

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 0

Requirements

1. 1

The provider must ensure the environment is safe and residents are protected. In order to achieve this the provider must:
(i) Ensure staff follow good infection control procedures by washing their own hands between caring for residents and offering all residents hand washing facilities before meals
(ii) Address the malodour in the units
(iii) Continue to remove unsafe, broken or damaged equipment from use
(iv) Ensure staff have enough pagers so that residents can call on available staff

(v) Ensure keys are available for staff and residents to open the locked bedroom doors within the home.

This is to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. SSI/2011/210 Regulations 4 (1)(a), 10(d) and 14. In making this requirement National Care Standards Care Homes for Older People Standard 4 Your environment.
Timescale:
(i), (iv), within 24 hours of receipt of this report.
(ii), (iii) and (v) by 28 February 2014

Statement 3

The environment allows service users to have as positive a quality of life as possible.

Service strengths

Our findings of the last inspection meant we graded the service weak for this quality statement. At this inspection we found some evidence of improvement. Further improvements, including progressing plans to change the indoor and outdoor space are necessary to allow service users to have as positive a quality of life as possible.

Following an upheld complaint we made the following requirement:
The provider must ensure that the home's garden is safe for residents to use.

As a result of this requirement the manager had carried out a general risk assessment of the garden and an assessment of the garden to make it more suitable for residents with dementia. This had resulted in an action plan. Some of the planned actions were:

- to add fencing to the garden to create a safe courtyard space
- improved planting
- to create points of interest such as a greenhouse, garden shed, bird feeding area and planters
- changing the garden door
- adding signage to guide people to the garden entrance
- fitting of a handrail on the slope leading to the garden
- adding safe seating.

The general risk assessment said that there would be a daily walk round of the garden area and dangerous objects would be removed. When we checked the garden during this inspection we found that the planned work had not commenced. However we did not find any of the dangerous objects that we found at previous inspection. We concluded that the system to make daily garden checks by the maintenance team supported by spot checks by the management team was effective.

The requirement to make the garden safe has been met. However, the work to improve the quality of the garden environment should be progressed.

We also followed up on a requirement to ensure that all bedding was fit for purpose. We saw that new bedding was in place. This requirement is met. The providers action plan said that key workers will review bedding on each residents' day. The residents' day is once per month. We concluded that this method would be ineffective in ensuring bedding is fit for purpose in a timely manner. Bedding should be checked by staff who make the bed on a daily basis. Any bedding unfit for purpose should be changed immediately. This is because inadequate bedding has the potential to cause or contribute to skin damage. We have asked the manager to review this with staff, to ensure, when bedding is checked to ensure an effective checking system is put in place.

Areas for improvement

A well planned and considered environment can play a crucial role in improving the quality of life for older people generally and particularly for those with cognitive problems such as dementia. We thought that more work was needed to improve the environment. For example the corridors were bland and clinical, with no points of interest where people who liked to walk could stop and touch tactile art work or look at photographs. We thought that the signage could be improved to help residents find their bedrooms. At this inspection we found there were plans to improve the environment. This had not yet led to visible changes.

At previous inspection, in some units, we observed that increasing noise levels was distressing for some residents. Noise needs to be kept at a level that allows residents to feel relaxed and to concentrate. During mealtimes on some units we saw that sudden and frequent noise from the kitchen area startled some residents. At this inspection we noticed there was greater recognition by staff of the impact of noise and the distress it could cause. When we carried out observations on all four units and at varying times of day we found that not all staff were aware of the impact of noise and unnecessary noise was inconsistently controlled. The service should work toward ensuring minimising distressing noise is consistently applied.
At this inspection we found that the quality of the environment had not changed consistently in a way which would lead to an improved experience for people.
Overall we have assessed the quality of the environment as weak. Lack of understanding and consideration of the potential impact of the environment resulted in poor outcomes for some residents. We have used the information from the other quality statements which affect the quality of life of residents to provide evidence for this quality statement.

Grade awarded for this statement: 2 - Weak

Number of requirements: 0

Number of recommendations: 0

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

Statement 1

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

Service Strengths

We concluded that there was little change in the findings of this quality statement since the previous inspection. We graded the service as weak for this quality statement.
The strengths of the services methods of participation as described in quality of care and support statement 1 (1.1) also apply to this quality statement and have contributed to the findings of the assessment of the quality of staffing.

Areas for improvement

Staffing changes continue to take place in the home. We spoke with the provider about staffing. We acknowledged that they had taken positive action to improve recruitment to the home and had made some staff appointments. During this inspection some of the newly appointed staff had taken up post and were receiving induction training. There was still a heavy reliance on agency staff within the home.
Some relatives made the following comments to us about staffing in questionnaires:
'I am quite happy with the care my relative receives at Pentland Hill Care Home. I hope that once staffing levels have been addressed things should be even better'.
'Overall efforts to provide care have good, positive attributes but continuity of staff presence cause problems at times'.
'Nursing staff levels need beefing up. OK in the morning (2 on duty) but only one at other times.'.
'Staff continually change so you do not build up a relationship with this. Key workers constantly changing'.

The provider should continue to work hard to recruit and retain staff to improve the quality and consistency of staffing in the home.

Grade awarded for this statement: 2 - Weak

Number of requirements: 0

Number of recommendations: 0

Statement 3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths

During this inspection we looked at planned staff training,oversight of practice, record-keeping and we observed how staff worked and interacted with residents. We have also taken into account evidence detailed in the other quality statements to grade this quality statement.
Some of the good practice we saw during the previous inspections remained in place. For example, the provider had a comprehensive induction package which included training for all new staff. A further training package was planned for all staff as part of the providers' action to address the Improvement Notice.
Experienced clinical services managers had been brought into the home. All four units had a clinical services manager who was responsible for teaching clinical skills and providing oversight of staff practice. Although still in place during this inspection, there were plans for newly appointed staff to take on the role of unit manager. As a result the temporary clinical services managers would no longer be working in the home. We have made further comments about this below.
Each member of staff had an individual learning plan which proposed to deliver training in a modular form and included e-learning.
Staff continued working hard to try to deliver care. Many were committed and caring. Again we saw some good practice in all four units of the home, in some aspects of care, but this was inconsistently applied over the five days of our inspection.

Areas for improvement

From our observations over the days of the inspection we concluded that staff were not always operating to National Care Standards, legislation and best practice. Overall we found there was improvement where staff were permanent and knew the residents well. Whereas we found there were concerns from residents and relatives when staff did not know residents. We also found that the care plan documentation did not provide accurate, person-centred, and individualised care plans which could be used by staff who did not know residents needs. Some work had been done to prepare summary sheets with residents essential needs. We found the format of this sheet was different in each of the four units and have commented on this in quality of management. We also found the information on the sheets was not always accurate. This may have potential for the wrong care to be provided.

Clinical services managers had been appointed to the units to guide practice and provide management and leadership. There were signs of improvement in some communication and some staff said they felt more supported. The impact of this role in changing cultures and improving practice had not yet been fully established at the last inspection. As described above these key personnel were about to change. We have discussed this with the provider who has said they will ensure there is a

transitional period. We comment on this further in quality of management and leadership.
Due to high staff turnover and recruitment and retention problems staffing of the units involved use of many agency workers who were unfamiliar with the residents. We noted that the provider had requested that the same agency staff returned where possible. We saw this was not always possible and due to sickness and absence agency staff were moved between units.The impact of this was that agency staff were not always given sufficient information to help them care for residents. We saw further examples of the impact this can have on residents when staff assist them to mobilise without using the correct equipment.
At previous inspections we noted that those in a unit manager or acting unit manager position did not always receive the supernumerary time allocated. During this inspection we were told that those currently acting as unit manager were supernumerary. We have asked the provider to continue to ensure this role is supernumerary while the improvements to meet the Improvement Notice are taking place. We have asked the provider to formalise this agreement through a variation process.
Notifications which have been made to us continue to support the view that staff are not always following best practice in moving and handling and medicines management.

At this inspection we still saw some examples of poor practice. When we observed staff practice we saw some staff appeared to lack the information, knowledge and skills needed to support older people with dementia;

- at mealtimes some staff did not offer appropriate assistance to help those who needed supervision or prompting to ensure their nutritional needs were met.
- some staff were not aware of the impact on the residents of the noisy environment during mealtimes
- staff did not know why some residents were not assisted to get out of bed
- there was a lack of interaction initiated by staff when they assisted residents who needed help with eating and drinking.

There was a greater awareness from staff about the residents needs in nutritional care. Although some staff still attributed residents' confusion and dementia for all of their difficulties, needs and behaviours, overall we saw more warmth, compassion and dignity when care was being given.
A staff training plan had been submitted to us. The training for staff had not yet taken place. We would expect that when staff have received the planned training and the learning is implemented that there would be further improvements in care.
Staff training is subject to enforcement by the Care Inspectorate and is reported in detail in quality statement 1.3 of this report.

Following two upheld complaints we made a requirement that service users be referred for appropriate medical advice as soon as possible when they show signs of illness or injury. During the October 2013 inspection we saw tha,t on the whole, staff called for medical assistance when appropriate and residents received medical advice and care they needed. We said we would continue to monitor the service performance of this through notifications made to us and at future inspection to ensure this is sustained.
During this inspection we found staff had called for medical assistance when appropriate and residents received medical advice and care they needed. This requirement is met.

From the questionnaires sent to us from relatives, we found 20 from 22 respondents said they felt more confident that staff would meet their relatives healthcare needs including arranging to see doctors, dentists and podiatrists if needed. Two respondents had concerns and disagreed with the statement. One respondent said:
'Whilst there is a vast improvement, I am still not confident staff pick up on deterioration quickly enough.'
Referral for medical advice is subject to enforcement by the Care Inspectorate and is reported within quality statement 1.3 of this report.
Staff supervision and oversight of practice is subject to enforcement by the Care Inspectorate and is reported within quality statement 1.3 of this report.

From our questionnaire responses we found only eight of the 22 respondents said their relative was encouraged to discuss their views with a keyworker.
One respondent said:
'Key workers are about to be reallocated, so not really sure at present. Named nurse tends to co-ordinate and update care plan'.

Five respondents said they disagreed that there were enough trained and skilled staff on duty. A further three did not know.

We have included some comments made to us by relatives which reflect their experiences:

'It is very noticeable that improvements in the home are taking effect, staff appear happier whilst working (both permanent and agency staff working as a team). This has a very positive and noticeable effect on the well being of residents',
'Overall efforts to provide care have good positive attributes but continuity of staff presence causes problems at times',
'Not witnessed hot snacks being served, but certainly improvement noticed re fluid and nutrition intake',
'It would appear that not all the members of staff know that my (relative) cannot stand on her own',
'I would say improvements have been taking place over the last four months. I have always found the staff to be helpful and caring.'

' We as a family are satisfied with the care my (relative) receives at Pentland Hill. We are grateful for the care he will allow the staff to give him and will support them in any way possible',
'There have been issues that I have not been happy with but can always speak to staff so that they can be resolved'.

Grade awarded for this statement: 2 - Weak

Number of requirements: 0

Number of recommendations: 0

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 1 - Unsatisfactory

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service.

Service strengths

We graded the service as weak for this quality statement.
The service methods of participation described in quality theme 1 statement 1 (1.1) also apply to this quality statement and have contributed to the grading of the Quality of Management and Leadership.
We saw some of the positive elements which were in place when we previously considered this quality statement remained in place. These were as follows:

- There were details within the home about how residents, relatives and their representatives could raise concerns directly with the provider. We found evidence that some families used this route to raise concerns.
- There was information in the home about how to contact the Care Inspectorate with concerns and complaints.

In November 2013, the provider had held two residents' and relatives' meetings to give information and answer questions about the management and leadership and the enforcement action which we have taken against the service. The meeting was attended by the Care Inspectorate and the City of Edinburgh Council.

We saw that 'You said-We did' information had been put at the entrances of the units. From this relatives and visitors could see what suggestions had been made by residents and relatives and how the management team had responded. This was an improvement to the information previously available. Thought should be given to how this information is shared with residents who do not find the entrance hall easy to access or who use a wheelchair and would be unable to see the board.

We spoke with relatives as part of our inspection. All of the relatives we spoke with said they had met the new manager and had the opportunity to discuss concerns, issues or have general conversation about the running of the home. We heard that senior BUPA managers had a presence in the home and were available to speak with residents and relatives.

Areas for improvement

The areas for improvement described in Quality of Care and Support 1.1 also apply to this quality statement.
We found evidence that information had been given to residents and relatives as described above. However, we could not find any evidence within the minutes of meetings, newsletter, notices or other written communications that residents and relatives had been consulted about changes to the management of the home or the units. We are mindful that the home have concentrated their efforts in meeting the improvements we have set out in the Improvement Notice and that the time and urgency of these would place limits on the ability of the service to consult widely about the management and leadership.

We found information about staffing and dependencies had been put at the entrance to each unit. The information in the format we saw would not be informative for relatives. We thought information about staffing could be presented in a clearer way.

Independent advocacy was not actively promoted or used routinely to help residents express their views.
We found that comments from residents and relatives were being discussed at management level. We would expect the service to continue to use the valuable feedback from residents and relatives to improve care, the environment, staffing about the management and leadership.

Grade awarded for this statement: 2 - Weak

Number of requirements: 0

Number of recommendations: 0

Statement 3

To encourage good quality care, we promote leadership values throughout the workforce.

Service strengths

Leadership and Management is subject to enforcement by the Care Inspectorate.
We have commented on the progress with leadership and management part of the Improvement Notice in section 1.3 of this report.
A number of systems and processes have been started which should improve the quality of care through promotion of leadership values. For example:

- there is evidence of strengthening leadership under the stewardship of the new manager

- an experienced clinical services manager has been working with staff in each of the four units to work directly in the unit, reinforcing good care and identifying poor practice
- the provider has recruited and appointed a house manager to each unit to provide leadership.
- clinical risk meetings take place daily to identify residents who need specific interventions to improve or maintain their health and well being
- care plans were being reviewed
- the home manager visited each unit every day to find out about the residents
- checks of staff competency were at an early stage
- the provider was recruiting new staff.

We concluded that the provider had taken positive action. However, the systems and processes needed time to become embedded. Currently they were not well enough established or sufficient to consistently make an impact on the quality of care or outcomes for people who use the service.

The newly appointed unit managers were on induction during our inspection in December, so, we were not able to measure the impact this will have on the quality of care and quality of management and leadership.
While the service is subject to an Improvement Notice the grade remains unsatisfactory for this statement.

Areas for improvement

There has been a high level of staff turnover in the home. We found that the provider used agency staff to cover staff shortages. During previous inspection we found some agency staff were not given sufficient detail about residents' care to allow them to meet their needs. We asked that this be addressed during the September 2013 inspection. A handover sheet had been produced for agency staff which provided essential information that agency staff must know before caring for residents. This differed on each unit and caused difficulties for staff working between the units. The manager agreed and has arranged for a single format to be used to provide consistency.
During the inspection we found evidence of unsatisfactory medicines management, food, fluids, nutritional care and tissue viability. We concluded that the provider was taking positive action to address our concerns. However, some of the issues from our earlier inspections remained and are described earlier in this report.
Leadership and management is part of the Improvement Notice. Further comments can be found under progress with the improvement notice in Quality of Care and Support statement 3 (1.3) of this report.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 0

Number of recommendations: 0

Statement 4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Service strengths

Quality assurance is included in leadership and management which is subject to enforcement by the Care Inspectorate.
We have commented on the progress with quality assurance, leadership and management part of the Improvement Notice in section 1.3 of this report.
At this inspection we found evidence of positive action which had been taken by the provider to put into place a framework of quality assurance systems and processes. While these were becoming established and embedded in practice we saw some improvement for residents. For example:

- new mattresses had been purchased and residents' mattresses had been reviewed and replaced
- a system had been introduced to ensure mattresses were cleaned and checked regularly
- the manager had made contact with the GP practices who serve the residents in the home to gain their views.

Since the current manager has been appointed we heard from relatives that they had more confidence in the management and leadership of the home.

Following two complaints made to us we made a requirement that the service must adhere to the complaints procedure at all times. We also made a recommendation about staff training in complaints handling. In order to achieve this the provider told us that themed supervision would be carried out. We could find no evidence that this had been carried out. However we saw that training in dealing with complaints was planned. We saw that the manager holds a complaints log. In this a record is kept of meetings in relation to complaints and the outcome and action from the meetings. Overall relatives told us they were more satisfied with how complaints were handled within the home and we have agreed that the provider has made sufficient progress for us to remove this requirement and recommendation.

Care service providers must inform the Care Inspectorate of certain events when they happen in the home. These are called notifications. Notifications can change our assessment of risk in the home and can influence when we carry out our inspections. These can help us assess whether the home has responded appropriately to events and if the provider is ensuring the health and wellbeing of residents. At previous inspections we were aware of a number of incidents, accidents and deaths which had not been notified to us. We made a requirement about this. During this inspection, we were aware that the system had improved. The service must continue to send us

notifications in a timely manner and in accordance with the guidance we have provided to them. This requirement has been met.

Areas for improvement

Further comments can be found under progress with the improvement notice in Quality of Care and Support statement 3 (1.3) of this report.

We found that the quality assurance systems and processes were starting to make an impact in the quality of care. This work needs to be consolidated and sustained.

Grade awarded for this statement: 1 - Unsatisfactory

Number of requirements: 0

Number of recommendations: 0

4 Other information

Complaints

Three complaints have been upheld since the last inspection. Two were related to healthcare and one related to palliative care. We have made requirements of the provider. These will be followed up at the next inspection of the service. Complaints information can be found on our website www.careinspectorate.com

Enforcements

We have taken enforcement action against the service. This action was taken under Section 62 of the Public Services Reform (Scotland) Act 2010. We issued an Improvement Notice to the service dated 13 August 2013 and extended the timescales for the service to meet these improvements in an Improvement Notice dated 5 November 2013.

Subsequently we have further extended the timescales of this notice. We informed the provider of this on 20 December 2013 and issued them with a letter, dated 13 January 2014, with the extension of timescales. The provider must meet the Improvements by 28 February 2014.

The Improvement Notice and extension of timescales can be found on our website www.careinspectorate.com

Additional Information

As part of this inspection a feedback meeting was held with senior BUPA management and the home manager on 20 December 2013. At the meeting we discussed the enforcement action we have taken against the service.

Senior BUPA management was informed that the Care Inspectorate would extend the timescales of the Improvement Notice where these had been reached. This is to give BUPA the opportunity to fully implement the work already begun to meet the necessary improvements. Senior BUPA management reinforced that they would make any necessary improvements.
The provider had already agreed to voluntarily suspend admissions to the home until the Improvements have been made.

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 the Care Inspectorate re-grading a Quality Statement within the Quality of Management and Leadership Theme (or for childminders, Quality of Staffing Theme) as unsatisfactory (1). This will result in the Quality Theme being re-graded as unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 1 - Unsatisfactory	
Statement 1	2 - Weak
Statement 2	1 - Unsatisfactory
Statement 3	1 - Unsatisfactory
Quality of Environment - 2 - Weak	
Statement 1	2 - Weak
Statement 2	2 - Weak
Statement 3	2 - Weak
Quality of Staffing - 2 - Weak	
Statement 1	2 - Weak
Statement 3	2 - Weak
Quality of Management and Leadership - 1 - Unsatisfactory	
Statement 1	2 - Weak
Statement 3	1 - Unsatisfactory
Statement 4	1 - Unsatisfactory

6 Inspection and grading history

Date	Type	Gradings	
11 Oct 2013	Unannounced	Care and support Environment Staffing Management and Leadership	1 - Unsatisfactory 2 - Weak 2 - Weak 1 - Unsatisfactory
3 Jul 2013	Unannounced	Care and support Environment Staffing Management and Leadership	1 - Unsatisfactory 2 - Weak 2 - Weak 1 - Unsatisfactory

14 Nov 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 3 - Adequate 3 - Adequate
14 Nov 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 3 - Adequate 3 - Adequate
18 Jun 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 3 - Adequate 3 - Adequate
20 Feb 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate
30 Sep 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 2 - Weak 3 - Adequate 3 - Adequate
6 May 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 4 - Good 3 - Adequate
17 Jan 2011	Re-grade	Care and support Environment Staffing Management and Leadership	2 - Weak Not Assessed Not Assessed Not Assessed
1 Nov 2010	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate Not Assessed 4 - Good Not Assessed
13 May 2010	Announced	Care and support	3 - Adequate

		Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good
26 Jan 2010	Unannounced	Care and support Environment Staffing Management and Leadership	2 - Weak 2 - Weak 2 - Weak 3 - Adequate
10 Nov 2009	Announced	Care and support Environment Staffing Management and Leadership	2 - Weak 2 - Weak 2 - Weak 2 - Weak
18 Mar 2009	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good 4 - Good
18 Feb 2009		Care and support Environment Staffing Management and Leadership	4 - Good 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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