Bennochy Lodge Care Home
Care Home Service

31a Bennochy Road
Kirkcaldy
KY2 5QY

Telephone: 01592642000

Type of inspection:
Unannounced

Completed on:
21 October 2025

Service provided by:
Rossa Home Care Ltd

Service provider number:
SP2022000076

Service no:
CS2024000104

About the service

Bennochy Lodge Care Home is registered to provide 24 hour care and support to a maximum of 17 older people. At the time of our inspection there were 13 people living there. The home is owned by Rossa Home Care Ltd.

The home is on one level and comprises of bedrooms, a communal lounge/diner and a garden area.

The home is in Kirkcaldy, Fife, easily accessible by public transport and close to local amenities.

About the inspection

This was a follow-up inspection which took place on 21 October 2025. The inspection was carried out by two inspectors from the Care Inspectorate.

We carried out a full inspection between 05 June 2025 and 09 June 2025 and concluded that people were experiencing significantly poor outcomes as a result of using the service. Please refer to inspection report dated 13 June 2025. The inspection highlighted critical weaknesses in relation to infection prevention and control (IPC) and the cleanliness of the home. We issued a serious concern letter on 06 June 2025 imposing a requirement. The inspection highlighted further critical weaknesses in aspects of the service which significantly impacted on the care people received. The Care Inspectorate issued an Improvement Notice imposing six required improvements to the provider on 18 June 2025 to address these issues.

The required improvements related to the environment, staff training, leadership and management, medication management and care planning. We carried out 13 monitoring visits in the period between the full inspection and the follow-up inspection. During this time the two required improvements relating to the environment were met within the agreed timescale of 02 July 2025. We extended the timescale for the required improvement relating to medication management twice to enable the provider to make the necessary improvements and we concluded this was met by 25 August 2025. We extended the timescale for the remaining required improvements relating to staff training, leadership and management, and care planning twice to enable the provider to make the necessary improvements and we concluded during this follow up inspection that these had been met.

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

In making our evaluations of the service we:

- spoke with five people using the service, and one of their relatives
- spoke with six members of staff and management
- observed practice and daily life
- reviewed documents.

Key messages

- Management and staff had worked hard to make the necessary improvements to meet the required improvements.
- Further improvement was needed to ensure people are offered activities and engagement that are meaningful to them.
- Care plans relating to end of life care and support needed to improve.

From this inspection we evaluated this service as:

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

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

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

How well do we support people's wellbeing? 3 - Adequate

There were two outstanding requirements relating to this key question. We were satisfied that these had been met. Details can be found in the 'outstanding requirements' section of this report. This had a positive impact on outcomes and experiences for people. To reflect these improvements we have regraded the quality indicators awarded at the previous inspection.

Opportunities for people to be active, engaged and doing things that they enjoy, were limited. The manager devised a weekly activity planner and staff were tasked with implementing it. However, we found no evidence to suggest people were consulted on how they would like to spend their time, or that the planner took account of people's likes, dislikes or preferences. The service had an 'open door' policy for visitors and improved efforts were being made to involve them in decisions about service delivery. People told us they liked when entertainers such as singers and pet therapists attended the home. However, there were no opportunities for people to leave the home or establish links with the local or wider community. This would support people to enhance their sense of wellbeing and independence (see requirement 1).

Requirements

1. By 03 December 2025, the provider must safeguard and promote people's physical, emotional and psychological health by ensuring people spend their time in ways that are meaningful for them. In order to achieve this, the provider must:

a) ensure people's wishes, interests and previous life history are discussed and documented
b) use this information to identify and provide opportunities for people to spend their time in ways that are meaningful and purposeful to them
c) keep accurate and evaluative records of the impact and outcomes of the support provided
d) provide appropriate training, guidance and support for all staff ensuring they understand the importance of meaningful and purposeful engagement and
e) ensure staffing levels are sufficient to provide appropriate, person-centred support for people.

This is in order to comply with Regulation 3 and Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirement for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that: 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors.' (HSCS 1.25).

How good is our leadership? 3 - Adequate

There was one outstanding requirement relating to this key question. We were satisfied that this was met. Details can be found in the 'outstanding requirements' section of this report. This had a positive impact on outcomes and experiences for people. To reflect these improvements we have regraded the quality indicators awarded at the previous inspection.

Management had a good oversight of clinical care, such as falls and nutrition which were well monitored, and actions taken were recorded. In addition to the manager, other members of the care team including nurses, were regularly taking part in auditing standards of care, for example care plan audits, daily environmental checks and mealtime observations. However, although we saw that some of these audits had identified areas for improvement, the person responsible for the improvement, and within what time scale, were not always recorded. This makes it very difficult to take appropriate action when identified improvements are not made (see area for improvement 1).

Areas for improvement

1.
To support a culture of responsive and continuous improvement, which meets the health and wellbeing needs of supported people, the provider should ensure that regular assessment of the service's performance is undertaken through effective audits. Where the audits identify areas for improvement, the improvements to be made must be detailed in an action plan which specifies the actions to be taken, the timescale within which the action is to be taken, the person or persons responsible for making the improvements, and the expected outcome of the improvement.

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

How good is our staff team? 3 - Adequate

There was one outstanding requirement relating to this key question. We were satisfied that this was met. Details can be found in the 'outstanding requirements' section of this report. This had a positive impact on outcomes and experiences for people. To reflect these improvements we have regraded the quality indicators awarded at the previous inspection.

Staff supervision had commenced and we were confident areas for improvement relating to staff practice were being identified and addressed. However, the supervisions were sporadic and needed to be carried out with all staff on a regular basis. Staff competency checks, including observation of practice were being carried out, but this needed to be more structured and formalised (see area for improvement 1).

Areas for improvement

1. To support good outcomes for people, the provider should ensure all care and nursing staff receive regular supervision and appraisals to make certain their learning and development needs are assessed, reviewed and addressed. Alongside this, the service should use formal observations of practice of all care and nursing staff to monitor standards of practice and competencies.

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

How good is our setting? 3 - Adequate

There was one outstanding requirement relating to this key question. We were satisfied that this was met. Details can be found in the 'outstanding requirements' section of this report. This had a positive impact on outcomes and experiences for people. To reflect these improvements we have regraded the quality indicators awarded at the previous inspection.

As part of one of the required improvements relating to the environment, the provider had to carry out an environmental audit and develop an action plan detailing how, and when, identified necessary improvements would be made. Improvements were being made on a priority basis. It is vital the action plan is adhered to ensure continuous, improved outcomes for people using the service (see area for improvement 1).

Areas for improvement

1.
To ensure people's safety, wellbeing and dignity, the provider should make certain the environmental improvement plan is adhered to and any areas for improvement identified are addressed timeously.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that 'I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.' (HSCS 5.22).

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

There was one outstanding requirement relating to this key question. We were satisfied that this was met. Details can be found in the 'outstanding requirements' section of this report. This had a positive impact on outcomes and experiences for people. To reflect these improvements we have regraded the quality indicators awarded at the previous inspection.

We concluded people's care plans had greatly improved and contained enough information to inform staff of how to best meet their needs. However, care staff told us they were not afforded dedicated time to familiarise themselves with the whole content of the plans. This is a missed opportunity to provide staff with useful information such as people's life stories which would give staff more insight, understanding, and commonality (see area for improvement 1).

Areas for improvement

1. To promote responsive care and ensure that people have the right care at the right time, the service provider should ensure that people have accessible, person-centred care plans in place that offer clear and up to date guidance to support staff.

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

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

Requirements

Requirement 1

By 2 July 2025, you must ensure that the health, welfare, and safety needs of people receiving care are met in relation to the environment. To do this, you must, at a minimum:

a) ensure there are effective laundry systems in place to minimise the risk of the spread of infection and preserve service users' dignity
b) ensure that all areas used in the provision of care are thoroughly cleaned
c) develop comprehensive cleaning schedules and an action plan of how these will be effectively implemented and monitored
d) share the action plan with the Care Inspectorate.

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

This requirement was made on 18 June 2025.

Action taken on previous requirement

On 04 July 2025 we carried out a monitoring visit. At that visit we saw that an external laundry service was being contracted to launder the day-to-day laundry in the service. The in-house laundry was being used only for items such as overnight bedding changes. A laundry assistant was available every day to do this.

All areas of the home had been deep-cleaned and comprehensive cleaning schedules were in place which the manager checked daily for completion. Another domestic had been employed and both domestic staff had received training from Fife NHS infection prevention and control (IPC) team. The domestic we spoke with was knowledgeable about their role and responsibilities. The cleaning schedules and action plan were shared with the Care Inspectorate.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result we have adjusted the grades awarded at the previous inspection.

Met - within timescales

Requirement 2

By 02 July 2025, you must ensure that the health, welfare, and safety needs of people receiving care are met in relation to the environment. To do this, you must:

a) carry out a comprehensive environmental audit and develop an action plan for refurbishment that identifies all areas of maintenance/refurbishment. The action plan must include timescales for completion of the work required and identify the individual with the responsibility for completing this work
b) share the action plan with the Care Inspectorate.

This is in order to comply with Regulation 4(1)(a) and Regulation 10(1) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 18 June 2025.

Action taken on previous requirement

The service submitted a provider submission in response to the Improvement Notice on 02 July 2025. This included a stabilization and transmission plan, cleaning, IPC, laundry plan, environmental audit and action plan. On 04 July 2025 we carried out a monitoring visit. We spoke with the provider and a representative from Insight Coaching and Consultancy; a service recruited by the provider to aid improvement. They were clear about the required improvements, and the action plans detailed how they are to be met and sustained.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result we have adjusted the grades awarded at the previous inspection.

Met - within timescales

Requirement 3

By 13 August 2025, you must ensure that staff receive training appropriate to the work they are to perform. To do this, you must, at a minimum:

a) demonstrate that all staff have received appropriate training and are competent to carry out the work they are to perform within the areas of:

1) infection prevention and control
2) Control of Substances Hazardous to Health (COSHH) and health safety
3) skin integrity
4) stress and distress management
5) medication and pain management
6) personal care and dignity.

b) demonstrate that there is an effective system in place to continually assess and record the training needs of staff.

This is in order to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and section 8 of the Health and Care (Staffing) (Scotland) Act 2019.

This requirement was made on 18 June 2025.

Action taken on previous requirement

We visited the service on 14 August 2025. We saw that all required training had been undertaken by the relevant staff. Reflective accounts and competency based spot checks on staff practice were being carried out by the manager, supported by one of the consultants. The service was continuing to receive support from NHS Fife's Infection Prevention and Control team and Fife's Health and Social Care Partnership's Care Home Liaison Team. Staff we spoke with said they had benefitted from their learning and saw better outcomes for people as a result.

Staff supervision had commenced and although we were confident areas for improvement relating to staff practice were being identified and addressed, supervision records required improvement to enable a clear audit trail of actions to be taken, and by whom.

Although the required training had been undertaken, to ensure staff are competent to carry out the work they are to perform, they must also be efficient at record keeping. The provider agreed that effective care planning is vital to ensure people's needs are being constantly evaluated and met. There was a required improvement in place relating to care planning. An extension to the timescale had previously been granted to enable the service to make the necessary improvements. During our visit on 14 August 2025 we saw progress was being made and the provider was aware of the further improvements required.

We agreed to extend the timescale to meet this required improvement until 25 August 2025.

We visited the service on 26 August 2025. Although we saw progress was continuing, we were not confident all staff were competent in record keeping, or the effective evaluation of people's care needs. Further improvement was required.

We agreed to extend the timescale to meet this required improvement until 17 October 2025.

We visited the service on 21 October 2025 and found care plans highlighted an improvement in staff's recording, evaluation, and triangulation skills. We saw evidence of action being taken when necessary for example, following up on medical advice and appointments. Communication between staff had improved which resulted in all staff being kept informed of any changes in people's needs.

Although staff supervision and competency checks were taking place, they were sporadic and needed to be more structurally scheduled. We have made an area for improvement. Please refer to the 'How good is our staff team' section of this report.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result, we have adjusted the grades awarded at the previous inspection.

Met - outwith timescales

Requirement 4

By 23 July 2025, you must ensure that service users experience a service which is well led and managed, and which results in continuous improved outcomes for service users through a culture of self-assessment and development, underpinned by robust and transparent quality assurance processes. To do this, you must, at a minimum:

a) ensure that there is a sufficient quality assurance system in place to continually monitor and evaluate the quality of the service provision to help inform improvement and development of the service
b) maintain a record of areas for improvement within the provision of care detailing the actions to be taken, the timescales within which action is to be taken, the individual with the responsibility for furthering improvement, and the expected outcome.

This is in order to comply with Regulations 3 and Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 18 June 2025.

Action taken on previous requirement

We visited the service on 25 July 2025. We found a comprehensive quality assurance 'tool bag' had been implemented within the service. This detailed a wide range of audits to be completed on a weekly, monthly, bi-annual, and annual basis, to monitor standards of care and support and evaluate people's experiences. This had only been commenced from July 2025; however, we were able to see some audits that had been carried out and these had generated actions for improvement. Due to this system being new, we were unable to review whether these actions had been implemented within the noted timescales and subsequently improved the experiences of people living in the service. Some monthly and weekly audits were still to be implemented, this included monitoring of falls, weights, care plan audits and oversight of restraint/restrictive practice. Further work is therefore required to ensure the service can effectively monitor and evaluate all areas of service provision.

The service shared with us their service improvement plan. This detailed the key focus areas for required improvement and development. Clear actions were recorded, including who was responsible for each improvement and the timescale. We saw this document clearly linked to the Health and Social Care Standards and The Care Inspectorate Quality Framework for Care Homes for Adults and Older People. The service should continue to use this to record findings and actions from their ongoing quality assurance.

We agreed to extend the timescale to meet this required improvement until 25 August 2025.

We visited the service on 26 August 2025. Despite the comprehensive quality assurance systems in place, we were not confident they were being implemented effectively. This was evidenced by the outstanding required improvements. Further improvement was required to establish staff roles and responsibilities and effectively manage accountability. This would support effective quality assurance and drive improvement.

We agreed to extend the timescale to meet this required improvement until 17 October 2025.

We visited the service on 21 October 2025 and saw further staff development in relation to roles, responsibilities, and accountability had been carried out. The nurses had been subject to competency checks and observation of practice in relation to quality assurance and driving improvement. Staff spoken with said they felt more confident in their role. The lead nurse told us things were much better as all staff were now assuming more responsibility.

Although we saw that some audits had identified areas for improvement, the person responsible for the improvement, and within what time scale, were not always recorded. We have made an area for improvement. Please refer to the 'How good is our leadership' section of this report.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result, we have adjusted the grades awarded at the previous inspection.

Met - outwith timescales

Requirement 5

By 2 July 2025, you must ensure that safe practice in relation to the management of medication is in place. To do this, you must, at a minimum:

a) ensure that there are protocols in place for the appropriate and safe administration of 'as required' medication. These protocols must include any non-pharmaceutical interventions to be carried out prior to administration
b) ensure that there is a protocol in place for assessing the effectiveness of the use of 'as required' medication
c) develop, implement, and regularly review pain assessment tools to be used to identify when a service user experiences pain and which details the action to be taken to alleviate or remove the pain
d) develop and implement medication audits that are informed by best practice guidance
e) ensure the medication used by service users is reviewed by relevant health professionals on a regular basis.

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

This requirement was made on 18 June 2025.

Action taken on previous requirement

On 04 July 2025 we carried out a monitoring visit. At that visit we saw improvements were being made to as required medication protocols. Links had been made with another provider via Scottish Care to support improvement. A representative was scheduled to attend the service on 05 July 2025 to deliver staff training on the effective implementation and use of the new protocols. Pain assessment and review tools were being implemented, and new audits had been developed to aid effective clinical governance of people's overall health and wellbeing, including medication management. The newly developed service improvement plan submitted to the Care Inspectorate on 03 July 2025 detailed how the required improvement would be met and sustained.

Overall, we saw some positive improvements; however, there was still work to be done to meet this required improvement. We agreed to extend the timescale to meet this required improvement until 23 July 2025.

We visited the service on 25 July 2025. We found that the service had implemented a new medication management system. This included an improved format for 'as required protocols'. Where 'as required protocols' were in place, most of these had been completed to a good standard. However, not all 'as required' medications had an associated protocol. We saw some people had more than one 'as required' medication type for a specific health condition. For example, management of stress and distress and bowel management. Consideration should have been given to developing protocols for specific conditions with guidance about which medication should be used and when.

Where people were prescribed medication with a flexible dosage option, clear guidance was needed for staff to follow about the decision-making process for dosages.

We saw that when 'as required' medication had been administered, it had been appropriately recorded, and that the effect was noted. Staff were including more detail of the benefit given by the medication.

When people required support with pain management, it was clearly detailed within their care plan and pain assessment tools were in place. We saw some examples of these tools being used; however, this was inconsistent. The service would have benefitted from further training of staff on the use of pain assessment tools. This could have ensured that people living with a cognitive impairment were effectively supported to manage pain. A range of new medication audits were in place. These were in the early stages of implementation. The service had identified where this was working and some areas where they would need to be amended, this included action planning. The service's audit did not include details of homely remedies. We found that several people had either pain or constipation medications duplicated across their medication administration record sheet and the homely remedy sheets. This increased risk of errors.

The homely remedies were not being reviewed regularly. We found examples of topical creams being used for people that were without a prescription label and or were being used for people but were not prescribed to them.

Overall, we continued to see some improvement. The service needed to continue to improve the management of people's medication protocols and its auditing systems to ensure consistent, robust, and safe practice.

We agreed to extend the timescale to meet this required improvement until 25 August 2025.

We visited the service on 26 August 2025. The service had implemented a new medication management system. This included an improved format for 'as required protocols', most of which had been completed to a good standard.

Staff had received further training on the use of pain assessment tools and a range of new medication audits were being implemented. The service had carried out a review of all homely remedies. Overall, we continued to see improvement.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result, we have adjusted the grades awarded at the previous inspection.

Met - outwith timescales

Requirement 6

By 23 July 2025, you must ensure that the health, welfare, and safety needs of service users are met in relation to care planning and risk assessments. In particular, you must ensure that all personal plans are reviewed when there is a significant change in a service user's health, welfare or safety needs, and that they contain up-to-date risk assessments and care plans which:

a) accurately reflect the assessed current health and care needs of the service user, with particular attention being given to stress and distress, end-of-life care, medication management, pain management, bowel management and nutrition
b) identifies the support required to meet the needs of the service user, the steps which should be implemented to address these needs, and the steps which should be implemented to mitigate any risks identified.

This is in order to comply with Regulation 4(1)(a) and Regulation 5 of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 18 June 2025.

Action taken on previous requirement

We visited the service on 25 July 2025. We sampled care plans and found that these had been reviewed and, in most cases, were up to date and reflective of people's current needs. We saw some stress and distress plans that were detailed and recorded person-centred information to guide care staff. We gave feedback to the service on where less detailed stress and distress plans could be enhanced to give person specific guidance on non-pharmaceutical and pharmaceutical interventions.

Sampling of end-of-life care plans found they lacked detail. We gave further best practice guidance to the service on how to enhance these plans to ensure they capture people's needs, wishes and preference at end stages of life.

Medication management plans we reviewed were not always in line with people's current medication needs. The service needed to review the level of detail recorded within these plans and a system for ensuring that these are kept up to date. The service also needed to review plans and protocols where more than one medication is prescribed to a person to manage a health condition or symptom, for example pain, bowel care or distress.

Guidance recorded in these plans and linked protocols should be clear, reflective of one another and direct care and support. Please refer to action taken on requirement five.

Overall recording of people's nutritional and personal care had improved. Care charts for food, fluids and bowel care were being consistently completed and, where required, this information was used to inform the need for any further intervention, for example GP referral, administration of 'as required' medication.

The service's attention to improving overall care planning records was evident. The service needed to continue to focus on ensuring that all plans were person centred, non-contradictory and cross referenced where relevant.

We agreed to extend the timescale to meet this required improvement until 25 August 2025.

We visited the service on 26 August 2025. We sampled care plans and found they had improved, and in most cases contained good, person-centred information. We saw some stress and distress plans that were detailed and recorded person-centred information to guide care staff. However, we also saw these were not always being adhered to by staff. For example, we saw one person showing signs of stress and distress because they were not being supported in accordance with their prescribed care.

Medication management plans we reviewed were not always clear and contained conflicting information. Guidance recorded in these plans and linked protocols should be clear, reflective of one another and direct care and support.

Overall, recording of people's nutritional and personal care had improved and care charts for food, fluids and bowel care were being consistently completed. However, staff were not always taking these into account when evaluating people's care needs. For example, we saw somebody's bowel chart highlighting the need to review/change their medication regime. This was not identified during the care plan evaluation which was having a detrimental effect on the person's health and wellbeing. We could not be confident that staff were fully familiar with people's needs as stated in the updated care plans. Neither were we confident that people's needs were being effectively evaluated to inform future care planning. The provider gave their assurance that plans were in place to make the necessary improvements.

We agreed to extend the timescale to meet this required improvement until 17 October 2025.

We visited the service on 21 October 2025 and saw further staff development had taken place in relation to care planning. Care plans sampled were detailed and reflective of people's current needs. It was clear that efforts had been made to ensure risk assessments and care plans gave clear, concise information to care staff. People's needs and wishes were reflected.

Care staff told us they were not afforded dedicated time to familiarise themselves with the whole content of the plans. We have made an area for improvement. Please refer to the 'How well is our care and support planned' section of this report.

We were satisfied that this required improvement was met. This had a positive impact on outcomes and experiences for people. As a result, we have adjusted the grades awarded at the previous inspection.

Met - outwith timescales

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	3 - Adequate

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

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

How good is our setting?	3 - Adequate
4.1 People experience high quality facilities	3 - Adequate

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

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