Stobhill Nursing Home
Care Home Service

70 Stobhill Road
Glasgow
G21 3TX

Telephone: 01414137050

Type of inspection:
Unannounced

Completed on:
12 December 2025

Service provided by:
Clyde Care Limited

Service provider number:
SP2016012834

Service no:
CS2022000211

About the service

Stobhill Nursing Home is registered to provide a care service to a maximum of 59 older people over the age of 65 and one named individual under the age of 65. It was taken over by a new provider, Clyde Care Ltd in 2022.

The home is a purpose-built two storey building in the residential area of Springburn in Glasgow. It is situated next door to Stobhill Hospital and is close to local shops and community amenities. The building provides single occupancy accommodation over two floors, all with partial ensuite facilities. There are public lounges and dining rooms as well as shared toilets and specialised bathing or showering facilities. People have access to a private, secured garden area accessible from the ground floor dining room.

There were 44 people using the service at the time of the inspection.

About the inspection

This was an unannounced inspection which took place on 9, 10 and 12 December 2025 between 10:00 and 20:30 hours. The inspection was carried out by three inspectors from the Care Inspectorate. 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 eight people using the service and 17 of their family members
- spoke with 18 staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Key messages

- People were being supported by a kind and caring staff team.
- Significant improvement was needed in aspects of supporting people's health and wellbeing.
- Quality assurance had increased however this still needed improvement.
- Improvement was needed to ensure personal plans accurately reflect the needs and wishes of people.
- Staff support and development were being prioritised by management through staff supervision and training.

From this inspection we evaluated this service as:

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

How well do we support people's wellbeing?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	3 - Adequate
How good is our setting?	3 - Adequate
How well is our care and support planned?	2 - Weak

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

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

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

At our last inspection we had set two requirements for the service to improve the health and wellbeing support for people. This included improving modified diets and risk around swallowing, and medication management. See section "What the service has done to meet any requirements made at or since the last inspection". The service had made some improvements but some further work was needed to fully meet the requirements. To accurately reflect what improvements still need to be made we have made new requirements to reflect this.

The catering team had information on people's textured diet needs, and staff had received International Dysphagia Diet Standardisation Initiative (IDDSI) training. However, this training had not been fully understood, with some confusion about modification levels and appropriate foods. As a result, people had not always been given the correct diets. Meals were sometimes poorly presented. As a result we observed some people choosing not to eat the modified diet offered to them. This posed risks to nutrition and meal enjoyment. However, people had been offered choice of food at mealtimes, showing progress in person-centred care. The service had not met all aspects of a requirement made at our last inspection, so we have made a new requirement to reflect what improvements still need to be made. (Requirement 1)

We identified gaps in the recording of fluids, with many people not achieving their target. There was no evidence that this had been recognised or acted upon to reduce the risk of dehydration. Some people were on food recording charts due to weight loss. While Malnutrition Universal Screening Tool 5 (MUST 5) assessments had been completed with treatment plans in place, there was little recorded evidence of diet fortification. Weight records were inconsistent, and treatment plans were not being reviewed in line with best practice guidance to monitor progress or deterioration. (Requirement 1)

Personal care monitoring records showed several instances where people had only received a full body wash rather than a shower or bath. This required oversight from management to ensure care met both individual needs and personal preferences. There were also occasions where people had declined oral care. This needed further exploration to understand the reasons and provide appropriate support. In addition, there were instances where records of administration of ointments and creams had not been completed. This needed to be addressed to maintain accountability and consistency in care delivery. (Requirement 1)

Medication ordering and stock control had improved, and returns medications were being appropriately managed. However, there were no written protocols or procedures to provide staff with ongoing guidance. The provider's policy did not include information on the management of returns medication. Medication administration competencies completed for staff responsible for administering medicines had not observed or discussed this area. This meant staff did not have consistent guidance or oversight to ensure returns medication was managed safely and in line with best practice. (Requirement 2)

During the inspection it was noted that some residents' bedrooms had been locked without a robust assessment of risk and benefit. This practice had not promoted people's rights or placed them at the centre of their care, nor had it taken account of guidance on rights, risks and the limits to freedom. As a result, residents' autonomy and dignity had been compromised, and the approach had failed to demonstrate person-centred decision making or adherence to best practice standards. (Requirement 3)

Requirements

1. By 23 January 2026 to promote the safety, health and wellbeing of people the provider must ensure staff receive essential training for their role and responsibilities.

To do this the provider must at a minimum:

a) Ensure all staff receive IDDSI training and have their competency assessed.
b) Ensure improved presentation of modified meals.
c) Have robust auditing processes in place to ensure people are receiving the correct diet.
d) Ensure all records relating to nutrition and hydration are consistently and timeously completed and take swift corrective action where needed.
e) Ensure all records relating to personal care are accurate and take swift corrective action when needed

This is to comply with Regulation 4(1)(a) and (b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 and Section 8 (a) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11), and "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)

2. By 23 January 2026 to ensure people are kept safe and their wellbeing is promoted the provider must keep accurate records of the medication they have taken.

As a minimum the provider must:

a) Establish written procedures for identifying, documenting, and returning unused, expired, or discontinued medications to the pharmacy.
b) Through monitoring processes ensure staff competency in understanding and implementation of best practice guidance for returns medications.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me" (HSCS 1.19) and "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)

3. By 23 January 2026 to promote people's rights and ensure positive outcomes for people in line with their choices and wishes, the provider must clearly demonstrate collaborative decision-making.

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

a) Have in place a locked door policy aligned to Mental Welfare Commission (2021) best practice guidance "Rights, risks and limits to freedom"
b) Ensure robust risk assessments are in place in relation to people's rights to protection from potential restraint.

c) Evidence collaborative decision making with relevant stakeholders, or people's representatives when legal powers are in place.

This is to comply with Regulation 4(1)(a)(b)(c) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice". (HSCS 4.11)

How good is our leadership? 2 - Weak

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

At our last inspection we had set a requirement for the service to improve their quality assurance processes to support positive outcomes for people. See section "What the service has done to meet any requirements made at or since the last inspection." The service had made some improvements but some further work was needed to fully meet the requirement. To accurately reflect what improvements still need to be made we have made a new requirement to reflect this.

The service improvement plan was created using clear goals that were specific, measurable, achievable, and time-bound. It was used as a working document. It was based on internal and external monitoring and evaluation. However, it was not clear that residents or their relatives had been involved in shaping the plan. This meant there was no evidence that their views were at the heart of service improvements.

Regular audits of key areas gave some assurance that monitoring processes were in place to spot improvements and maintain standards. When actions were identified, there was some tracking and follow-up, which supported improvements. However, this was not always written down clearly. This reduced confidence that all issues were dealt with in a systematic way. Some audit tools needed further development to be more effective. In addition, some issues found in audits were not carried forward into an action plan. This meant people could not be confident that everything was being addressed. This limited the impact of audits on driving lasting improvement. (Requirement 1)

Systems were in place to make sure the manager had oversight of accidents, incidents, and adult protection concerns. Analysis was carried out, and a new monthly report was introduced to support clinical oversight and look at themes and trends. Although this was still at an early stage, it had the potential to provide a more structured approach to monitoring, helping the service to spot recurring issues, track patterns, and put in place targeted improvements.

Requirements

1. By 23 January 2026 the provider must ensure people are safe, risk is reduced and people receive quality care and support that meets their needs. To do this, the provider must, at a minimum:

a) Ensure audits are consistently completed.
b) Ensure audit tools in use are robust to more fully identify improvement and reduce risk.
c) Ensure plans are in place to action and complete issues identified in the audit process.
d) Ensure strong management oversight of the quality assurance processes.

This is to comply with Regulation 3 and 4(1)(a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011

This is to ensure that care and support is consistent with the 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 systems". (HSCS 4.19)

How good is our staff team? 3 - Adequate

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

At our last inspection we had made a requirement for the service to improve their staffing arrangements. This requirement had been met and can be found in section "What the service has done to meet any requirements made at or since the last inspection".

The management team had undertaken a review of the staff skills and staff gender mix throughout the service. Rotas sampled indicated that there was an appropriate mix of male and female staff, sufficient to meet people's needs and preferences. We also observed a better balance of male and female staff on shift in each unit during the inspection. This represented progress since the last inspection.

There had been a significant focus on staff supervision demonstrating that staff support and development were being prioritised by the management team. This had helped identify where there were gaps in staff knowledge and development. Training records showed management had begun to address the identified training need of staff to ensure they had the right skills and knowledge to carry out their roles safely and effectively. This supported better outcomes for people using the service.

Competency assessments had begun to be completed. To ensure that staff practice was consistent, safe, and aligned with the standards expected, this needed further development and to be embedded in practice.

How good is our setting? 3 - Adequate

We re-evaluated this key question to adequate, where strengths only just outweighed weaknesses.

At our last inspection we had made a requirement for the service to improve the environment and the maintenance arrangements. This requirement had been met and can be found in section "What the service has done to meet any requirements made at or since the last inspection".

The home was welcoming, clean, tidy and free from offensive odours. It had been nicely decorated for the festive period and this had been appreciated by people and their families.

We looked at cleaning records completed since the last inspection. These were up to date and being consistently assessed and completed. Local maintenance records we reviewed were consistently completed. However, not all areas identified as needing repairs or improvement were systematically added to an action plan. This meant that some issues might not have been followed up properly. This reduced confidence that all necessary repairs and improvements were being addressed in a structured way. During the previous inspection we observed not all required safety checks had been addressed in a timely manner. On our inspection we noted this had been addressed by the provider. This meant people, families and staff could be confident they were safe and protected from potential risk whilst in the building.

The storage of equipment, used to support people with their mobility was not suitable. We saw this equipment had been left in people's personal spaces, such as bedrooms, and in communal areas including bathrooms and shower rooms. This impacted on people's privacy and dignity as their personal space was being used for storage rather than for their own comfort. In addition, storing equipment in these areas reduced the accessibility of facilities, limiting people's ability to use them freely and comfortably. (Area for improvement 1)

The service had an ongoing refurbishment programme in place. This included painting communal areas, redecorating bedrooms, and updating furniture. This represented a commitment to improving the living environment for people, making shared spaces more welcoming and personal areas more comfortable. It also showed that the provider was investing in maintaining standards and creating a homely atmosphere.

There was a secure garden area available for people and their families to use. The garden appeared tidy and well kept, with paved areas suitable for walking safely. Because of the time of year, we saw limited use of this space. However, when people did choose to spend time there, they had access to a variety of seating options which were in good condition. The garden gave people and their families the opportunity to enjoy fresh air and spend time together in a safe setting.

Areas for improvement

1. To ensure people have accessibility to facilities and to maintain people's dignity and respect the provider should ensure appropriate storage of equipment used to help people move or transfer.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me". (HSCS 1.19)

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

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

At our last inspection we had set a requirement for the service to improve their personal planning to support positive outcomes for people. See section "What the service has done to meet any requirements made at or since the last inspection." The service had made some improvements but some further work was needed to fully meet the requirement. To accurately reflect what improvements still need to be made we have made a new requirement to reflect this.

Personal plans we viewed highlighted that improvements were still required. Evidence showed that plans were not consistently updated when people's needs changed, meaning important information was out of date. In cases where updates had been made, these were not applied consistently throughout the personal plan document. This created gaps and contradictions. Such inconsistencies risked causing misunderstandings among staff, particularly those who do not know the individual well. This meant they may be unsure how best to provide appropriate support and meet individual's needs. Furthermore, some documents within the care plans no longer reflect people's current circumstances, reinforcing the need for a more robust and reliable system of review and update. (Requirement 1)

Personal plans were audited, but often by the same staff who wrote them. This reduced objectivity, as staff were less likely to spot gaps or challenge their own work. As a result, important issues could have been missed. A more robust system of auditing, involving independent reviewers or cross-checking by different staff, would have helped ensure that personal plans were accurate, up to date, and fully reflective of the support people needed. (Requirement 1)

Six monthly reviews of personal plans had taken place. However, the process did not accurately reflect the future needs wishes and outcomes for people experiencing care in the service. (Requirement 1)

Requirements

1. By 23 January 2026 the provider must ensure that information in personal plans is up-to-date and sets out the health, welfare and safety to meet people's needs. To do this, the provider must, at a minimum:

a) Ensure personal plans are updated when a person's needs change and this is consistently evidenced throughout the plan.
b) Ensure all appropriate care plans are in place and reviewed regularly.
c) Ensure information which no longer reflects people's needs is removed and archived.
d) Ensure the auditing of personal plans is robust and objective.
e) Ensure personal plans six monthly reviews include focused future outcomes for people.

This is to comply with Regulation 5(2)(a) (b) (c) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

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 December 2025 to promote people's wellbeing and reduce the risk of choking while respecting peoples' right to food choice, the provider must, as a minimum:

a) Serve food and drink in line with individual assessments, as outlined by the International Dysphagia Diet Standardisation Initiative (IDDSI) framework.

b) Ensure all staff involved in food preparation and food serving receive training in IDDSI framework levels of modification and choking risks.

c) Regularly audit meals to confirm texture matches prescriptions and adjust practices as needed.

d) Provide at least two options per meal, including for those on modified diets.

This is to comply with Regulation 4(1)(a) and (b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 and Section 8 (a) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11), "My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected" (HSCS 1.23) and "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)

This requirement was made on 17 October 2025.

Action taken on previous requirement

While there had been improvement in some areas of this requirement, further work is needed to ensure all aspects of the requirement are met. We have rewritten this requirement to reflect what the service must focus on, this can be found in section "How well do we support people's wellbeing?"

This requirement will therefore show as met in line with our guidance as a further requirement has been made.

Met - within timescales

Requirement 2

By 2 December 2025 to ensure people's wellbeing and comply with best practice for managing returned medication the provider must, as a minimum:

a) Ensure appropriate oversight of medication ordering and maintain adequate stock for people living in the service.

b) Develop and follow written protocols for ordering, reordering, and checking stock levels.

c) Establish written procedures for identifying, documenting, and returning unused, expired, or discontinued medications to the pharmacy.

d) To support audit trails and accountability, log all returned medications with details including but not limited to, the person's name, medication name, reason for return, and date.

e) Store returned medications in a locked, clearly labelled container separate from active stock until collection or disposal.

f) Provide training for all staff involved in medication handling on the returns medication protocols to ensure their understanding and implementation of the correct procedures.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me" (HSCS 1.19) and "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)

This requirement was made on 17 October 2025.

Action taken on previous requirement

While there had been improvement in some areas of this requirement, further work is needed to ensure all aspects of the requirement are met. We have rewritten this requirement to reflect what the service must focus on, this can be found in section "How good do we support people's wellbeing?"

This requirement will therefore show as met in line with our guidance as a further requirement has been made.

Met - within timescales

Requirement 3

By 2 December 2025 the provider must ensure people are safe, risk is reduced and people receive quality care and support that meets their needs. To do this, the provider must, at a minimum:

a) Develop a dynamic service improvement plan that is informed through quality assurance activities and feedback from people.

b) Ensure that systems of quality assurance and audits are consistently completed.

c) Ensure detailed actions are addressed timeously through action plans.

d) Develop an overview of all significant events and a comprehensive analysis of all accident, incidents and such events.

e) Include an evaluation of progress made.

This is to comply with Regulation 3 and 4(1)(a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 .

This is to ensure that care and support is consistent with the 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 systems". (HSCS 4.19)

This requirement was made on 17 October 2025.

Action taken on previous requirement

While there had been improvement in some areas of this requirement, further work is needed to ensure all aspects of the requirement are met. We have rewritten this requirement to reflect what the service must focus on, this can be found in section "How good is our leadership?"

This requirement will therefore show as met in line with our guidance as a further requirement has been made.

Met - within timescales

Requirement 4

By 2 December 2025 the provider must ensure people's preferences are respected and staff are supported to confidently deliver care. To do this, the provider must, at a minimum:

a) Routinely assess rotas to ensure a mix of male and female staff is present, reflecting the preferences and needs of the people receiving care.
b) Provide regular supervision in line with the provider's policy.
c) Ensure all staff are provided with appropriate training, regular competency assessments and personal development opportunities.
d) Ensure there is a comprehensive overview of staff training attendance.

This is to comply with Regulation 4 (1)(a) and (b) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 and Section 7(1) and 8(1)(a) of Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me" (HSCS 1.19) and "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 4.14)

This requirement was made on 17 October 2025.

Action taken on previous requirement

This requirement was met. Please see narrative in "How good is our staff team?" section of this report.

Met - within timescales

Requirement 5

By 2 December 2025 the provider to ensure the safety of people, visitors, and staff.

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

a) Develop and maintain a documented timetable for daily, weekly, monthly, and annual checks covering all areas of the premises.
b) Conduct regular and timely environmental safety checks.
c) Log all checks with dates, findings, and actions taken.
d) Address identified risks promptly and record actions taken.

This is to comply with Regulation 4 (1)(a) and Regulation 10(2)(b) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My environment is secure and safe". (HSCS 5.17)

This requirement was made on 17 October 2025.

Action taken on previous requirement

This requirement was met. Please see narrative in "How good is our setting?" section of this report.

Met - within timescales

Requirement 6

By 2 December 2025 the provider must ensure that information in care plans is up-to-date and accessible and sets out the health, welfare and safety to meet people's needs.

To do this, the provider must, at a minimum:
a) Identify where information can be streamlined and take action to carry this out.
b) Ensure a review of the care plan is carried out at least every six months, or if there is a significant change.

This is to comply with Regulation 5(2)(a) (b) (c) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

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)

This requirement was made on 17 October 2025.

Action taken on previous requirement

While there had been improvement in some areas of this requirement, further work is needed to ensure all aspects of the requirement are met. We have rewritten this requirement to reflect what the service must focus on, this can be found in section "How well is our care and support planned?".

This requirement will therefore show as met in line with our guidance as a further requirement has been made.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To ensure the garden is free of debris and safe for people using it, the provider should:

a) Conduct regular visual inspections of the garden area.
b) Remove any hazardous items promptly.
c) Records are maintained to provide evidence of these checks.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that : "My environment is secure and safe" (HSCS 5.17) and "I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment". (HSCS 5.22)

This area for improvement was made on 17 October 2025.

Action taken since then

This area for improvement has been met. Please see narrative in "How good is our setting?" section of this report.

Previous area for improvement 2

To maintain high standards of cleanliness and reduce the risk of cross-contamination, the service should ensure:

a) Adequate numbers of external waste bins are provided to meet the needs of the home.
b) External bins are maintained in a state of good repair.
c) The external bin area is checked at regular intervals throughout the day to ensure bins are not over-full, lids are closed and the surrounding area is kept clean and free of debris.
d) Records are maintained to provide evidence of these checks.

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)

This area for improvement was made on 17 October 2025.

Action taken since then
Not assessed at this inspection.

Previous area for improvement 3

To ensure better evidence that people continue to experience activities that are right for them and meet their needs the provider should:

a) Ensure staff accurately record the activities people engage in daily.
b) Ensure information is recorded in a way that details the level of people's engagement in activities and the outcome achieved.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me". (HSCS 1.19)

This area for improvement was made on 17 October 2025.

Action taken since then
Not assessed at this inspection.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

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

How good is our staff team?	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	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?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak

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