Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Murdostoun - Brain Injury Rehabilitation Centre, Lanarkshire

Service Provider: Active Neuro Limited

4–5 March 2025

This report is embargoed until 10.00am on Thursday 15 May 2025

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 29–30 March 2023

Requirement

The provider must ensure that external clinical waste ins are kept locked at all times.

Action taken

The large storage bins used to store clinical waste bags were not locked. **This requirement is not met** and is reported in Domain 5: Planning for Quality (see requirement 1 on page 25).

What the service had done to meet the recommendations we made at our last inspection on 29–30 March 2023

Recommendation

The service should ensure all complaint information directs service users and families to Healthcare Improvement Scotland at any stage of their care or treatment in all documentation.

Action taken

We saw complaints information had been updated to include contact details for Healthcare Improvement Scotland.

Recommendation

The service should review the patient care records and expand the range of information audited as part of the patient care record to ensure that documentation was organised in a clear and structured way.

Action taken

We reviewed the service's care planning and record-keeping audit. We found patient care records were not consistently organised and information was not easily accessible. This recommendation is reported in Domain 7: Quality Control (see recommendation b on page 29).

2 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an unannounced inspection to Murdostoun - Brain Injury Rehabilitation Centre on Tuesday 4 and Tuesday 5 March 2025. We spoke with a number of staff and service users during the inspection. We received feedback from 2 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Lanarkshire, Murdostoun - Brain Injury Rehabilitation Centre is an independent hospital providing neurorehabilitation for brain injury or other neurological conditions.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For Murdostoun - Brain Injury Rehabilitation Centre, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service had a clear vision and purpose, with a comprehensive strategy and defined objectives for continuous improvement. A governance framework was in place with visible and supportive leadership.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient and staff feedback was regularly gathered to inform ongoing improvement into how care was delivered. A quality improvement plan and staff training also helped to improve how the service was delivered. An audit programme and policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. Safer recruitment processes were in place. A duty of candour report was published every year. Clinical waste bins that store clinical waste bags must be kept locked. The service's infection prevention and control policy should be updated to reference current legislation and best practice.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and well maintained. Staff were safely recruited into the service. Staff working in the service showed care and compassion to patients. Patient care records and legal documentation must be accurately completed and easily accessible. Appropriate procedures should be carried out for the prevention of infection and control. Staff training for carrying out enhanced observations of patients should be provided as outlined in the provider's policy.	✓ Satisfactory

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

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Active Neuro Limited to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in three requirements and four recommendations.

Implementation and delivery	
Requirement	
1	The provider must ensure that external clinical waste bins are kept locked at all times (see page 25). Timescale – immediate *Regulation 3(d) (ii)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* This was previously identified as a requirement in the March 2023 inspection report for Murdostoun - Brain Injury Rehabilitation Centre.
Recommendation	
a	The service should update its infection control policy to reference Healthcare Improvement Scotland's Infection prevention and control standards 2022 and National Services Scotland's national infection control manual (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Results

Requirements

2 The provider must ensure that all legal documentation regarding DNACPR and Adults with Incapacity Act are fully completed and easily accessible (see page 29).

Timescale – immediate

Regulation 4(3)(b)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

3 The provider must improve the standard of record keeping in the patient care record to ensure they are easily accessible and updated when there is a change in the delivery of care. All records mut be accurately completed, dated and signed by the healthcare professional (see page 29).

Timescale – immediate

Regulation 4 (2)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Recommendations

b The service should review the patient care record records and expand the range of information audited as part of the patient care audit to ensure that documentation was organised and in a clear and structured way (see page 29).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

This was previously identified as a recommendation in the March 2023 inspection report for Murdostoun - Brain Injury Rehabilitation Centre.

c The service should ensure communication with all staff regarding infection prevention and control issues is robust and consistent (see page 29).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Results (continued)	
d	The service should ensure that all staff have the appropriate training in line with the provider's observation policy (see page 29). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: Find an independent healthcare provider or service – Healthcare Improvement Scotland

Active Neuro Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Murdostoun - Brain Injury Rehabilitation Centre for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service had a clear vision and purpose, with a comprehensive strategy and defined objectives for continuous improvement. A governance framework was in place with visible and supportive leadership.

Clear vision and purpose

The service provides specialist inpatient rehabilitation for patients in recovery from a brain injury or other neurological conditions.

The provider's vision was 'a world where people with the most complex needs are surrounded by the collaborative, holistic and expert care they require and the kindness they deserve, to live a brighter future and their best lives.' This was stated on its website and displayed on the hospital noticeboard for staff and patients. This information was also shared with new staff as part of the induction process. A set of core behaviours informed its strategic direction, the delivery of care and culture in the organisation. The core behaviours were:

- being kind and honest
- to be fair and inclusive, and
- to listen, learn and act.

These behaviours were clearly displayed in the service and on its website.

Key objectives set out the goals of the provider's strategic vision. Examples of these included:

- Commercial – build strong existing services and have a bold and exciting growth plan.
- Financial – financially stable and sustainable.
- Quality, safety and clinical excellence – delivery of good quality and safe services.
- People and culture – a diverse and inclusive place to work.

An electronic centralised reporting system was used to gather information to help measure the provider's success in achieving its strategic objectives. Examples of this included reducing the risks of harm to patients, medication management, incident management and complaints. Staff-related indicators included staff training compliance. The system produced a live report for all the services in the provider organisation to help monitor and inform a cycle of improvement and development.

The service had its own mission and vision statement developed by the multidisciplinary team 'together we help patients, and their loved ones navigate their neurorehabilitation journey as skilled, compassionate and cohesive team'. This was displayed in the entrance of the hospital for staff and incorporated into staff and patient meeting agendas.

We saw the service had its own aims, which fed into the provider's vision. Examples include:

- goal-based rehabilitation
- holistic approach to medical, physical and psychological, cognitive, social and care needs
- multidisciplinary working
- patient-centred assessment and rehabilitation
- providing a caring and friendly environment, and
- therapeutic relationships based on mutual trust and integrity.

We saw that senior management in the service regularly monitored and evaluated the service's performance.

- No requirements.
- No recommendations.

Leadership and culture

The service had a diverse workforce of staff to reflect the complex needs, support and specialist interventions required of its patients. This included:

- administration staff
- consultant clinical neuropsychologist and psychology assistants
- consultant in rehabilitation medicine
- consultant neuropsychiatrist
- head of therapy and rehabilitation assistants
- healthcare assistants
- housekeeping and maintenance staff
- nurses, and
- physiotherapists and occupational therapists.

We saw a staffing protocol was in place to make sure appropriate staffing numbers and skill mix were on duty. We were told staffing numbers would be increased depending on patient needs if required. Nursing staff and senior management told us that senior nursing staff had authority to request agency or bank staff should an emergency occur out of hours.

The service had an on-call system in place that included a member of the senior management team and medical staff.

The hospital director, unit manager and head of therapy provided senior hospital management support. The majority of staff we spoke with told us that the senior management team was supportive and accessible. Comments from our staff survey included:

- 'Head of Therapy is very effective in addressing any issues brought to her and will bring issues to us.'
- 'My line manager – Therapy is supportive and fair.'

We saw the provider promoted the 'freedom to speak up' initiative to promote patient and staff safety and had developed a freedom to speak up policy. Staff could approach a freedom to speak up guardian in the organisation directly for advice and signposting. We saw freedom to speak up posters displayed with contact details for a confidential whistleblowing service for staff.

The monthly wellbeing meeting had a focus on improving staff wellbeing. We saw that the provider had developed a recent wellbeing strategy, where

services could submit a wellbeing business plan to be considered to promote the wellbeing of staff and patients. We were told the service had won an additional car for patient transport and had been awarded a sum of money to improve the staff room. As a result, the service had developed a wellbeing action plan where staff feedback was considered for furniture and decor of the staff room. An employee assistance program was available to staff. This provided independent counselling services, as well as legal and financial advice. It also provided specific support to managers who had identified staff in need of support.

Every year, the provider's chief executives hold leadership meetings with service leaders across the organisation to share provider updates. We saw a leadership portal was available on the provider's intranet which all staff could access.

We were told the provider's operational manager visited the service every month to engage with staff and support the hospital director.

The service provided opportunities for staff development and continuous professional development. We saw staff performing leadership activities had access to development programmes to support them in their role. For example:

- the head of therapy had recently registered for Scottish Vocational Qualification (SVQ) level 4 in social services and healthcare, and
- the ward manager had been supported to apply for enhanced clinical leadership training.

We were told the provider had recently released training for managers, including training for:

- investigations
- performance management
- recruitment, and
- supervision.

These helped senior staff gain further knowledge and skills to lead the service and departments more efficiently and effectively.

A governance system was in place with a clear organisational structure, as well as a schedule of meetings, reporting pathways and details of quality performance monitoring systems. This helped make sure delivery of care in the service was safe.

The service's monthly local clinical governance meeting followed the same agenda as the 3-monthly regional clinical governance meeting that the hospital director or head of therapy attended. Any actions from the local clinical governance meeting were included in the service's improvement plan. The head of therapy carried out a clinical governance audit every 3 months, which the provider's quality team oversaw.

We attended one of the daily morning meetings where senior members of staff, including maintenance staff attended. The meeting discussed:

- admission and discharges
- estates and maintenance scheduled work
- incident reviews
- patient health, wellbeing and observation levels
- planned appointments or activities for patients
- referral updates
- staffing levels, and
- visitors attending the service.

The service held a variety of regular staff meetings, with documented outcomes and actions. We saw meetings for:

- all staff
- maintenance, housekeeping and kitchen staff
- senior management
- senior nurses
- senior support workers, and
- therapy and rehab staff.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patient and staff feedback was regularly gathered to inform ongoing improvement into how care was delivered. A quality improvement plan and staff training also helped to improve how the service was delivered. An audit programme and policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. Safer recruitment processes were in place. A duty of candour report was published every year.

Clinical waste bins that store clinical waste bags must be kept locked. The service's infection prevention and control policy should be updated to reference current legislation and best practice.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The provider's website and service's welcome brochure provided information to patients and carers about:

- the environment and facilities available
- the service and the patients it support
- treatments and range of therapies available, and
- staff working in the service.

A participation policy was in place, and we saw the service engaged and gathered feedback with patients and carers in a variety of ways. This included:

- an anonymous suggestion box located in the reception
- monthly magazine
- newsletters
- patient forums
- patient satisfaction questionnaires, and
- QR code.

We saw the service displayed its previous Healthcare Improvement Scotland inspection report on its website and was available in the reception area of the ward.

Patients were allocated a key worker, named nurse and associate support care worker. Patients and carers were given the opportunity to feedback through one-to-one sessions with nursing or therapy staff. Any feedback from patients gathered in their one-to-one sessions were documented in the patient care record and shared with the multidisciplinary team. We were told staff had developed their responses to help make sure that families and carers got the information that they needed in a simple and understandable way. This relied on avoiding jargon, technical explanations and providing an update on how the patients were achieving independence day-to-day.

All patients were invited to attend and participate in monthly patient forum meetings. During the meetings, patients were encouraged to discuss any concerns about the service and to offer suggestions for activities, outings and the standard of food. A minute was taken with any proposed actions evaluated at the next meeting. Examples of improvements included food takeaways at the weekend, as well as outings and activities.

The patients that we spoke with were very positive about the way that the staff group supported them. They appreciated the way that the therapy team would take an interest and constructed their treatment individually.

The service actively engaged and worked collaboratively with external stakeholders. We were told the service had good working relationships with:

- community rehabilitation teams
- health and social care partnerships
- local GP services
- NHS services, and
- physical healthcare teams.

This helped the service to plan and provide safe, person-centered care with input from a range of healthcare professionals to meet the needs of patients.

Formal links had also been established in the voluntary sector including Headway Brain Injury Association and the Scottish Head Injury Forum (SHIF). We were told that a variety of staff had represented the service in the wider brain injury networks. This provided opportunities to share information and keep the service up to date with best practice.

The service engaged with staff in a variety of ways to communicate updates, gather feedback and discuss improvements, including:

- email updates
- staff intranet site
- staff meetings, and
- staff surveys.

Every 3 months, the provider's chief executive held meetings to update staff on improvements the organisation had made. We saw staff were invited to attend this remotely and the sessions were recorded and available on the staff intranet.

Staff surveys were sent out regularly and results were shared with staff. We saw staff surveys sent out in March 2024, September 2024 and another survey was to be sent out on the 10 March 2025. We reviewed the results of the surveys and saw changes completed as a result, which included a focus on staff wellbeing. The service had a monthly recognition award scheme in place, where staff could nominate each other for going above and beyond in their role. We saw staff were provided with wellbeing activities, including an awards night held in a local community hall and pamper days.

- No requirements.
- No recommendations.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

The service fully understood Healthcare Improvement Scotland's notification process and the need to inform Healthcare Improvement Scotland if certain events or incidents occur.

The complaints policy sets out timeframes and expectations for how complaints would be managed. Information on making complaints to Healthcare Improvement Scotland was available in the service. We noted the service had not received any complaints in the last 12 months.

A process for recording and investigating incidents and accidents was in place. All incidents and accidents were recorded on the electronic reporting management system. A clear process was in place to fully investigate, and

review incidents and we saw examples where incidents had been managed in line with this process. An investigation form included details of:

- a full description of the incident and immediate actions taken
- an action plan for improvement
- an incident review and investigation
- assigned incident category
- sharing lessons learned with staff.

We saw accidents and incidents discussed at the daily morning meeting and in the local clinical governance meetings. Serious incidents were escalated to the executive teams. The service had recently introduced a weekly incident review meeting with the ward manager, senior nurses and senior healthcare assistants, with oversight from the hospital director. We were told this was set up to be more inclusive of staff working in the ward and help them to devise action plans, where needed.

The provider produced a 'lessons-learned' bulletin to share lessons learned across the organisation. This was shared with staff monthly and displayed on staff noticeboards. This provided transparency of any incident and oversight from the provider.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The service had a duty of candour policy in place and a yearly report was available on the service's website.

Governance structures and comprehensive policies and procedures helped support the delivery of safe, person-centred care. Policies were reviewed regularly or in response to legislation, national guidance and best practice. To support version control and accessibility, policies were available electronically on the staff intranet. We saw policies for:

- infection prevention and control
- observation
- physical health, and
- safeguarding (public protection).

Most patients were referred to the service from NHS boards and we were told good working relationships had been developed with the NHS. Processes were in place to assess the suitability of patients for admission. This included a senior

member of the multidisciplinary team carrying out a pre-admission assessment with the patient. We saw this assessment consider the physical and emotional needs for rehabilitation and whether the service met the needs of the patient. This assessment was then discussed with the wider multidisciplinary team and the admission and discharge manager would allocate a key worker to begin the admission process.

We saw patients were provided a range of treatments and support to help with their rehabilitation. This included a timetable of activities and a range of one-to-one sessions with their keyworker and therapies to promote their independence and improve their wellbeing.

During our inspection, we attended a weekly multidisciplinary team meeting. This included liaison with local rehabilitation community teams, community supports and social work. We saw evidence of collaborative working and representation of the patients' views. We found a holistic approach to planning care and treatment, along with an environment that was open and transparent when discussing the roles of the professionals present at the meeting. Each patient was invited to attend their own patient review, held every 4–8 weeks.

Careful consideration was given to discharge planning including the support patients and carers would need to continue their rehabilitation upon leaving the ward. Pre-discharge meetings were held between the multidisciplinary team and services that would support the patient on discharge. This included a comprehensive overview of strengths and needs of the individual, which complied with the assessment transfer and discharge policy held in the service.

While in the service, patients were temporarily registered with a local GP practice and a contract was in place with an external pharmacy to supply prescribed medication and provide a pharmacist to visit the service each week. The pharmacist carried out a range of audits and safety checks, including:

- controlled drug audit every month
- patients' medication administration record
- regular checks of medicines, and
- safe storage and disposal of medicines.

An electronic monitoring system was in place with the pharmacy supplier for raising any issues or actions required following an audit. Senior nursing staff and ward manager were alerted to any issues or outcomes from audits.

During our inspection, we discussed some medication errors, including controlled drugs reported to Healthcare Improvement Scotland before the

inspection. We saw the provider had reviewed its controlled drug policy and the service had developed a local protocol and processes to make sure its medication handling and disposal was safe.

The service did not stock medication. The patients' local GP prescribed medication following recommendations from medical staff in the service. Medication, including controlled drugs were stored securely and appropriately in the pharmacy room. Nursing staff were identified on each shift to sign for keys for the controlled drug cabinet to make sure that no unauthorised member of staff could access controlled drugs. We saw evidence that controlled drugs were counted and checked with two registered nurses between each shift. We also saw evidence that the hospital director carried out weekly controlled drug audits.

Policies were in place for recruitment, induction and staff development. The provider's human resources department, as well as an on-site human resources manager supported the service's recruitment process. This helped make sure that suitably qualified staff were recruited.

All new staff joining the service completed an induction program and mandatory training, as well as a probationary period of 6 months. During this time, staff were given a welcome pack and their performance in their role was appraised. Staff who successfully completed this probationary period were offered a full-time position.

A process was in place to make sure ongoing reviews of professional registrations and regular Protecting Vulnerable Groups (PVG) reviews were carried out.

Staff performance was monitored through supervision and yearly appraisals. Monthly audits were carried out to check compliance and any issues were highlighted to managers to address.

The service provided opportunity for staff development and continued professional development. We saw each staff member had a dedicated training programme accessible on the staff intranet learning hub. This provided mandatory and access to additional training if staff were interested in an area of training or education. At the time of our inspection, 80% of face-to-face training had been completed. We saw the service had supported a member of staff to complete their nursing registration qualification.

The service continued to have good links with the local NHS board to provide staff training to improve patient care, such as tracheostomy care and physical health monitoring.

The service had links with local universities and colleges, supporting nursing and allied health professional students' opportunities to carry out clinical placements in the service. We saw the service had received positive feedback from students about their placement, supportive from staff and opportunities for learning.

What needs to improve

The service's infection prevention and control policy did not reference or include information on Healthcare Improvement Scotland's *Infection Prevention and Control Standards (2022)* or the National Services Scotland *National Infection Prevention and Control Manual* (recommendation a).

At the time of our inspection, we saw six outstanding appraisals from 2024. We will follow this up at future inspections.

- No requirements.

Recommendation a

- The service should update its infection control policy to reference Healthcare Improvement Scotland's *Infection Prevention and Control Standards (2022)* or the National Services Scotland *National Infection Prevention and Control Manual*.

Planning for quality

Systems were in place to proactively assess and manage risks to staff and patients to make sure that care and treatment was delivered in a safe environment. This included:

- auditing
- reporting systems
- risk assessments detailing actions taken to mitigate or reduce risks
- risk register, and
- staff meetings.

The service's risk register was regularly reviewed and was a standing agenda at the health and safety and clinical governance meeting. Examples of risks on the register included:

- fire safety
- health and safety

- safeguarding issues
- staffing and recruitment.

The service had an up-to-date fire risk assessment and we saw that appropriate fire safety equipment and signage was in place. We also saw more specialist risk assessments for managing key building risks, such as legionella (a water-based infection).

Personal evacuation plans for patients were in place, readily accessible and updated regularly.

Environmental walk rounds were carried out weekly to inspect the premises for any potential hazards or areas of improvement. This helped to ensure the environment was clean, safe, and well-maintained.

An estates reporting system was in place for staff to report any maintenance issues. We saw that any jobs that the service's maintenance staff could not repair were assigned to external contractors, which the service's estates manager oversaw. Maintenance contracts were in place and checks were carried out on patient equipment, such as:

- baths
- hoists
- mattresses, and
- patients' beds.

The ward manager and staff held monthly health and safety meetings, with oversight from the estates manager. The ward manager also meets monthly with the head of estates to discuss health and safety. We saw health and safety posters displayed throughout the service. This helped staff to deliver care in a safe and supportive environment.

The provider's quality team set out a comprehensive yearly programme of clinical and non-clinical audits to help deliver consistent, safe care for patients and identify areas of improvement. Audits carried out included those for:

- health and safety
- infection control, including hand washing
- restrictive interventions (nursing interventions to manage patient risk), and
- safeguarding (public protection).

Audits were recorded on the electronic reporting management system. The service's quality team could access the results and make sure the audits were completed appropriately, on time and that required actions had been carried out. Audit results and actions were discussed at clinical governance meetings.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. The service had a comprehensive quality improvement plan that the provider's executive team could access to review the service's progress. We saw that this plan included information from:

- audits
- clinical governance
- complaints
- feedback, and
- incident reviews.

The hospital director and senior managers held monthly site improvement plan meetings, where the service's quality improvement plan was reviewed and any actions taken following an audit. Examples of improvements included:

- purchase of new dining room tables and chairs
- purchase of new lounge sofas
- replacement of flooring through the ward, and
- staff breakout room upgraded.

We were told the provider was in the process of developing internal inspections to assess the service's performance around key aspects of its registration with Healthcare Improvement Scotland and quality assurance activity.

What needs to improve

The large storage bins and clinical waste bins were not locked. This had been identified as an issue during the previous inspection in March 2023 (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must ensure that external clinical waste bins are kept locked at all times.

- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The environment was clean and well maintained. Staff were safely recruited into the service. Staff working in the service showed care and compassion to patients.

Patient care records and legal documentation must be accurately completed and easily accessible. Appropriate procedures should be carried out for the prevention of infection and control. Staff training for carrying out enhanced observations of patients should be provided as outlined in the provider's policy.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

During our inspection, we saw the team working well together with the patients offered a variety of interventions designed to help them regain independence in daily living. Staff we spoke with showed care and compassion, as well as a high level of specialist knowledge. Staff also told us they enjoyed working in the service.

We observed one mealtime at midday, which a member of the catering team coordinated, with assistance from support workers from the ward. The patients could choose to eat with each other in the dining room or take their meals to their room if they preferred. A choice of meals was offered, and we saw some patients receiving extra assistance where required.

The environment was clean and well maintained. Cleaning schedules were in place and up to date. We saw evidence that individual equipment was cleaned after each use. Appropriate cleaning solutions were available, including chlorine-based products for sanitary fixtures and fittings. All cleaning materials and equipment were stored in appropriate areas in the service, with limited

access for staff only. We saw linen was stored and managed in line with the *National Infection Prevention and Control Manual*.

We reviewed four patient records and found a range of assessments, care plans and risk assessments. We saw that each patient had person-centred care plans, which focused on the goal of maintaining or regaining independence that included mental and physical health needs. We found evidence of multidisciplinary working, engagement with community support and carer input.

The seven staff file we reviewed contained appropriate background checks completed to show staff had been safely recruited, including:

- professional registration checks and qualifications
- PVG status, and
- references.

Staff files also included information on each staff member's induction and appraisals. The service had a process in place to maintain ongoing reviews of professional registrations. We also saw evidence that regular PVG checks were carried out, as required to make sure staff remained safe to continue working in the service.

As part of our inspection, we asked the service to circulate an anonymous staff survey. From our staff survey, 67% of the staff who responded said they would recommend the organisation as a good place to work and able to influence how things were done in the organisation.

- '…the organisation takes the wellbeing of patients and staff seriously.'
- 'Involvement in aspects of service development is encouraged.'
- 'Very much so… line manager is very active in listening and communicating with the therapy team… they act on appropriate issues and cascades information as necessary.'
- '… provides a patient-centred multidisciplinary team rehab service led by dedicated and experienced staff.'

What needs to improve

During our inspection, we found some incomplete DNACPR documents and section 47 adults with incapacity forms. We highlighted this to the manager and the responsible medic while on-site (requirement 2).

Electronic and paper patient care records were not consistently or accurately completed. Old or undated information was found in the most current paper records. We also found information differing between the electronic and paper records. For example:

- Assessment information kept in some patients' rooms was not completed or up to date.
- Risk assessments were not all complete.
- Care plans were updated monthly. However, these did not appear to be updated after a change of care or treatment.
- We saw three patients on supported observation during the inspection and this was evident in the handover information given to the nurse in charge of the ward. However, this information was not updated in electronic care plans.
- In one patient care record, we saw a pressure area assessment that highlighted high risk of pressure sores. We saw care prescribed for positional changes and skin integrity checks. However, we were not able to identify a care plan for pressure care.

This means that information may be missed and cause confusion for staff, increasing the risk to patients (requirement 3).

We reviewed the service's care-planning and record-keeping audit. While this audit was completed regularly, it did not ensure that patient care records were organised, structured and easily accessible. This was highlighted in the previous inspection carried out in March 2023 (recommendation b).

We were told an infection control lead was responsible for disseminating information and supporting staff. During our inspection, we saw some patients who we were initially told were being 'barrier nursed' due to infection. Staff told us that public health had been alerted to the three patients developing the same infection and enhanced infection prevention and control precautions were being followed. However, not all staff were clear about the precautions to take, and we observed no signage alerting staff of additional requirements for personal protective equipment or managing the patient environment. We spoke with a domestic member of staff who was not aware which patients required additional precautions when cleaning their environment. Therefore, we are not assured of a whole team approach to infection prevention and control. We also found some staff were wearing jewelry, which is not compliant with infection control precautions (recommendation c).

We reviewed the provider's observation policy, which advised that staff should all have a knowledge assessment before carrying out supported observations. Managers told us this had not been rolled out to staff (recommendation d).

Requirement 2 – Timescale: immediate

- The provider must ensure that all legal documentation regarding DNACPR and Adults with Incapacity act are fully completed and easily accessible.

Requirement 3 – Timescale: immediate

- The provider must improve the standard of record keeping in patient care records to ensure they are easily accessible and updated when there is a change in the delivery of care. All Records must be accurately completed, dated and signed by the healthcare professional.

Recommendation b

- The service should review the patient care records and expand the range of information audited as part of the patient care record to ensure that documentation was organised in a clear and structured way.

Recommendation c

- The service should ensure communication with all staff regarding infection prevention and control issues is robust and consistent.

Recommendation d

- The service should ensure all staff have the appropriate training in line with the provider's observation policy.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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