Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Graham Anderson House, Glasgow

Service Provider: The Disabilities Trust

29–30 April 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 27–28 September 2023

Requirement

The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance.

Action taken

The service appropriately notified Healthcare Improvement Scotland of all relevant events. **This requirement is met**.

Requirement

The provider must introduce a maintenance programme for the laundry facilities to ensure temperatures are reached for effective decontamination.

Action taken

Housekeeping staff explained and demonstrated how they made sure that the correct temperatures were reached while laundering linen. The maintenance team was part of this process and helped make sure the washing machines were operating correctly. **This requirement is met**.

Requirement

The provider must ensure policies and procedures are in place with specific guidance and responsibilities for staff who dispense medication.

Action taken

The service had developed and implemented a local medication management procedure for staff working in Heather unit. **This requirement is met**.

Requirement

The provider must update its complaints policy to include the full name, address, telephone number and email address for Heathcare Improvement Scotland, including a statement making it clear that patients and carers have a right to complain to Healthcare Improvement Scotland at any time. The feedback form available in public areas must also be updated with Healthcare Improvement Scotland's contact information.

Action taken

The complaints policy was reviewed and made clear that patients could contact Healthcare Improvement Scotland (HIS) at any time. The contact details for HIS were correct. In each patient room, a welcome pack included HIS details, including how and when to make a complaint. A public-facing complaint procedure was available on the service's website. **This requirement is met**.

Requirement

The provider must ensure they have an effective process to manage patient safety alerts so that on receipt, they are disseminated and acted on appropriately, with any action documented and reported at future governance meetings.

Action taken

The service had established an effective system to manage patient safety alerts as part of the corporate quality and risk digital alert management system. **This requirement is met**.

Requirement

The provider must ensure appropriate procedures are carried out for the prevention and control of infection in particular:

- *a process for the disposal of single-use equipment after use and*
- *develop a risk assessment and action plan for the decontamination of hands.*

Action taken

The clinical hand wash basin in the treatment room had been fixed, which allowed staff to decontaminate their hands. However, during our inspection we observed staff re-using single-use equipment, including medication cups and syringes. **This requirement is not met** and is reported in Domain 7: Quality control (see requirement 4 on page 29).

What the service had done to meet the recommendations we made at our last inspection on 27-28 September 2023

Recommendation

The service should monitor and evaluate the improvements made as a result of staff feedback, to determine whether actions taken have led to the anticipated improvements.

Action taken

We saw evidence that the service had evaluated the improvements made as a result of staff and patient feedback. This was reported in the 3-monthly governance report.

Recommendation

The service should have clear guidance in writing for staff using cleaning products specifying concentrations and area for use.

Action taken

Housekeeping staff showed us how they followed the manufacturer instructions to make sure that any chlorine-based cleaning products complied with infection prevention and control guidelines, as stated in *The National Infection Prevention and Control Manual*.

Recommendation

The service should clearly record if patients have been offered advocacy service and if these have been refused.

Action taken

Advocacy services were available in the service. From the patient care records we reviewed, we saw that patients had been offered advocacy services.

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 Graham Anderson House on Tuesday 29 and Wednesday 30 April 2025. We spoke with a number of staff, patients and carers during the inspection. We received feedback from 37 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Glasgow, Graham Anderson House is an independent hospital providing specialist assessment and rehabilitation for people with a nonprogressive acquired brain injury.

The inspection team was made up of four inspectors.

What we found and inspection grades awarded

For Graham Anderson House, 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 mission statement and defined aims and objectives. Key performance indicators allowed the service to measure its performance and embed continuous improvement in the delivery of care. The service had a skilled and diverse staffing complement to meet the specialised needs of patients with complex brain injury. The service had clear structures for reporting and escalating concerns. Local clinical governance meetings should be re-commenced.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The service had established good links with the local community, accessing local activities and facilities. Patient and staff feedback was actively encouraged and used to inform improvements. Policies and procedures helped staff deliver patient-centred care. Processes for staff recruitment, induction and training were in place. A comprehensive programme of audits helped staff to deliver safe patient care. Appropriate systems and processes must be in place for medication, in particular for controlled drugs. Findings from the legionella risk assessment must be acted on.	✓ Satisfactory
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 and the staff described the provider as a good employer. Patient care information must be easily accessible in patient care records. National infection prevention and control procedures must be followed. Patient care plans should be accessible to patients and in easy-read format.	✓ 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 The Disabilities Trust 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 four requirements and two recommendations.

Direction	
Requirements	
	None
Recommendation	
a	The service should re-commence local clinical governance meetings to provide monitoring and oversight of safe patient care provided in the service (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery

Requirements

1 The provider must ensure that appropriate systems, processes and procedures are in place for the management of medications, in particular medicines classified as controlled drugs (see page 23).

Timescale – immediate

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

2 The provider must action the findings of the legionella risk assessment and ensure a legionella management plan and checks on water outlets and storage tank are in place (see page 25).

Timescale – by 19 August 2025

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

Recommendations

None

Results

Requirements

3 The provider must improve the standard of recordkeeping in patient care records to ensure that they are easily accessible to all staff delivering patient care (see page 29).

Timescale – by 19 August

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

Results (continued)
4 The provider must ensure that appropriate procedures are carried out for the prevention and control of infection (see page 29). Timescale – immediate *Regulation 4(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation
b The service should ensure that care plans are accessible to patients and developed in easy-read format for patients to have a better understanding of the treatment goals and progress (see page 29). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 2.17

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

The Disabilities Trust, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Graham Anderson House 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 mission statement and defined aims and objectives. Key performance indicators allowed the service to measure its performance and embed continuous improvement in the delivery of care. The service had a skilled and diverse staffing complement to meet the specialised needs of patients with complex brain injury. The service had clear structures for reporting and escalating concerns.

Local clinical governance meetings should be re-commenced.

Clear vision and purpose

Graham Anderson House is part of The Disabilities Trust (trading as 'Brainkind'), which is a brain injury charity. The charity had a clearly stated vision of, 'A world where life after brain injury is a life well lived.'

The charity had clear and well-displayed values for all employees:

- Agile - forward thinking, responsive and flexible.
- Resourceful - spend time and money wisely, empower the people.
- Connected - collaborative, to listen and learn.
- Courageous - do the right thing, be bold and aspirational.
- Heart - dedicated, passionate and act with humility.

The corporate strategy had clear and defined strategic objectives, including:

- To build positive and sustainable services reaching as many people as possible.
- Deliver leading edge clinical practice and thinking around brain injury.
- Drive social action around brain injury and ensure more people's needs are met.

We saw measurable key performance indicators (KPIs) for each objective, including:

- build a research programme
- build new fund-raising channels
- develop pathways from acute placement to community settings
- increase occupancy, and
- share expertise and improve service wide practice.

Graham Andeson House had adapted the corporate objectives in line with the local service delivery and had defined KPIs to reflect the adapted objectives. The KPIs were evaluated in the service's improvement plan and fed into quality improvement for the future. We saw that the KPIs for 2025–2026 were:

- increase the participation of patients in all aspects of the service delivery
- maintain good compliance with standards of external regulators, and
- upgrade the environment and facilities to provide a comfortable and stimulating environment.

We could see that the service was involving patients in staff recruitment and extensive plans were in place for environmental upgrade in 2025.

- No requirements.
- No recommendations.

Leadership and culture

Due to the specialist nature of the care pathway, the service employed a high number of specialist healthcare professionals. This included:

- activities co-ordinator
- brain injury counsellor
- clinic psychologist/neuropsychologist
- consultant psychiatrist
- nurses
- occupational therapists
- physiotherapists
- speech and language therapists, and
- therapy assistants

Clinical support staff and a variety of ancillary staff (including housekeeping, catering and maintenance staff) helped to support this staffing team.

The service had a well-defined reporting structure and staff reported a high level of job satisfaction. A recent corporate 'Closed Culture' survey from the provider confirmed staff were happy in their respective roles, acknowledging the positive cultural change with the diverse employment strategy. The corporate team had recently created a REACH group (Race Ethnicity Culture Heritage). A member of the Graham Anderson House team was elected to this group and was given the time to participate in meetings to support, share learning and value ethnic diversity in the workforce.

Each day started with a 30-minute handover in each unit. All staff groups were represented at these meetings and each patient's care and progress was discussed, as well as any incidents or reportable events from the corporate digital reporting platform.

Each Sunday evening, the nurse in charge prepared a weekend report for the manager, which detailed:

- concerns
- issues and activities
- patient status, and
- reportable events.

This was emailed to be received ahead of the Monday morning report.

The registered manager or a designated deputy reviewed safety alerts at the weekend to make sure no urgent actions were required to maintain patient safety.

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. We were told the service had an open-door policy for all staff to have access to the senior team. Staff we spoke with told us they would feel safe to speak up.

The registered manager attended regular regional meetings, where the service was benchmarked against the other Brainkind units. The regional meetings also gave an overview of all aspects of the services, including:

- accidents and incidents
- clinical governance
- lessons learned, and
- health and safety.

What needs to improve

While the regional clinical governance meetings were taking place, we were told that the local clinical governance meetings had not taken place since spring 2024 (recommendation a).

We reviewed an audit that the provider had carried out. In the audit, staff noted corporate visitors to the service did not always introduce themselves or engage with the wider team if they met them on duty or in the rest areas. It had been agreed the corporate team would wear badges to identify them and their role and will make every effort to engage with all staff during their visit. We will follow this up at future inspections.

- No requirements.

Recommendation a

- The service should re-commence local clinical governance meetings to provide monitoring and oversight of safe patient care provided in the service.

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

The service had established good links with the local community, accessing local activities and facilities. Patient and staff feedback was actively encouraged and used to inform improvements. Policies and procedures helped staff deliver patient-centred care. Processes for staff recruitment, induction and training were in place. A comprehensive programme of audits helped staff to deliver safe patient care.

Appropriate systems and processes must be in place for medication, in particular for controlled drugs. Findings from the legionella risk assessment must be acted on.

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

- staff working in the service
- the environment and facilities available, and
- the service and the patients supported.

We were told that patients and their carers had the opportunity to visit the service before their admission to hospital, where appropriate. This helped patients, relatives and carers become familiar with the service and the environment.

Information boards displayed in the service shared information about daily activities and menus.

Patients were encouraged and supported to take part in service improvement and development. For example, we saw evidence that patients had been part of the service's interview process for new staff, as well as in the provider's safeguarding meeting. During our inspection, we also saw a patient participating in gardening projects in the service. We were told that a patient had recently provided a presentation about brain injury to students at a local university.

An activity co-ordinator was in place and we saw patients were asked for suggestions for activities. A variety of activities and therapies were available to support and maintain patient health and wellbeing. Patients had access to therapy rooms, including an indoor and outdoor gym, therapy kitchens and outdoor garden space.

The service had established good working relationships with local charities and leisure centers. Patients were encouraged and supported to attend local attend local amenities, such as woodwork placements and sporting activities.

The service engaged with and gathered feedback from patients and carers in a variety of ways, including:

- a feedback folder
- a patient bulletin
- a suggestion box, and
- patient forums.

Patients were invited to participate in monthly patient forum meetings and encouraged to discuss what was working well in the service and what could be improved on. This included the environment, staffing, activities and the quality of food. Minutes were taken with any proposed actions highlighted. Examples of improvements included:

- a group where patients discussed the news
- changes to the food menu and themed foods, and
- independent access to the outdoor gym area for patients, where appropriate.

The service communicated updates, gathered feedback and discussed improvements with staff in a variety of ways, including:

- a staff noticeboard
- online messaging systems
- staff meetings, and
- staff surveys from the provider and the service.

The service had recently invited staff to complete a survey asking what they thought could be improved for patients, staff and the environment. Results

from this had been reviewed and shared with staff, identifying areas of improvement that had been actioned.

Following feedback from staff, the service had introduced new initiatives, such as a 'person we support day'. During these days, staff carried out patient tasks (such as physical health monitoring) for patients staying in certain rooms on a designated day. This gave patients and staff more structure in delivering this care. An evaluation of this initiative documented in a 3-monthly governance report showed positive outcomes.

A member of Graham Anderson House had been nominated for the provider's staff recognition scheme for their actions and kindness during extreme weather in January 2025. The service also had a local, monthly recognition and reward scheme in place. Staff could give digital cards and members of staff that colleagues had nominated during the month received a small gift and thank you from the manager.

The service 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, and
- NHS services and local authorities.

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

The service was part of the Brain Injury Network Glasgow, Scottish Head Injury Forum (SHIF) and Scottish Acquired Brain Injury network. This provided opportunities to share information and keep the service up to date with best practice.

- 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.

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

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

The service's complaints policy set out timeframes and expectations for how complaints would be managed. Information about how patients could make complaints to Healthcare Improvement Scotland was available in the service. The service had received two complaints in total and we saw they had been managed in line with the service's complaint policy.

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.

Policies and procedures were reviewed regularly or in response to changes in legislation, national guidance and best practice. To support version control and accessibility, policies were available electronically on the staff intranet.

Electronic patient care records were password-protected. Paper-format patient care records were stored securely in the staff duty room. Policies for the management of information were in place. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

Patients were referred to the service from their local NHS boards or local authority. 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 that this assessment considered the physical and emotional needs of the patient and whether the service met the needs of the patient.

We saw patients who were admitted under the Mental Health (Care and Treatment) (Scotland) Act 2003 had all the required paperwork in place related to treatment and medication. This included 'suspension of detention' paperwork to authorise and allow patients to spend time outside of the hospital grounds.

On admission, patients were allocated a named nurse and key worker. This included a timetable of activities and a range of one-to-one sessions with their key workers and therapies to promote their independence and improve wellbeing. Patients who were detained under the mental health act met with the consultant psychiatrist. We saw that the multidisciplinary team regularly reviewed patients to discuss their needs and progress of rehabilitation and discharge planning. Family members were kept informed of patients' care and treatment.

While in the service, patients were temporarily registered with a local GP practice and a local pharmacy supplied their medication. We saw the service had an agreement with the GP to visit the service twice a week and patients had access to general healthcare services.

An electronic incident reporting system was in place to record any accidents or incidents. The service's process to investigate and review incidents included:

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

We saw that each incident was emailed to members of the service's senior management team, the provider's clinical governance group and included in the 3-monthly governance report. The service had recently developed an incident management policy following a medication error.

Policies were in place for safe recruitment, induction and staff development. The provider's human resources department supported the service with the recruitment process. Systems were in place to make sure all staff had up-to-date Protecting Vulnerable Groups (PVG) background checks.

All staff members carried out an induction programme. This included face-to-face training e-learning and shadowing opportunities for their role. Examples of training included that for:

- brain injury
- fire safety
- infection prevention and control, and
- safeguarding (public protection).

We saw staff members who had recently been recruited had a 6-month probationary period. It was evidenced that each member of staff had a formal 3- and 6-month review and that they received formal communication when they passed their probationary period.

A variety of training and education courses were available for staff. We saw evidence that all mandatory training had good rates of completion and senior management monitored this.

The service provided opportunities for staff development, including opportunities for staff to access Scottish Vocational Qualifications (SVQ) level 2 and level 3 in health and social care. We were told the provider's learning and development department would consider staff requests for additional training in areas of interest. Staff we spoke with during the inspection told us that the senior management team had supported them to access additional training.

Staff performance was monitored through supervision and yearly appraisals. Processes were in place to monitor the service's healthcare professionals, including registration with professional regulatory bodies and revalidation.

What needs to improve

The service did not stock medication. The patient's local GP prescribed medication following recommendations from medical staff in the service. During the inspection, we reviewed the service's medication management processes, including for controlled drugs. While a controlled drugs policy was in place, we found the processes in place to manage controlled drugs did not make sure that these medicines were managed safely. For example:

- a process to identify which staff member was responsible for handling the controlled drug keys was not in place
- controlled drugs were not counted between shift changes
- medication belonging to a patient was left in the hospital after that patient was discharged from the service
- the controlled drug book was not stored securely, and
- unlabeled medication that was not classified as a controlled drug was stored in controlled drug cabinet.

We also found inconsistent processes in place for the storage of Diazepam. This could lead to confusion for staff for handling medication (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must ensure that appropriate systems, processes and procedures are in place for the management of medications, in particular medicines classified as controlled drugs.

- No recommendations.

Planning for quality

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

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

A risk register was in place as part of the service's risk management process, which demonstrated a proactive approach to identifying and managing risk in the service. The service carried out a wide range of risk assessments, including those for:

- fire safety
- health and safety
- physical aggression, and
- staffing.

We saw up-to-date servicing checks for electrical safety, fire safety and patient equipment.

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

- controlled drugs
- health and safety
- infection control
- medication management, and
- patient care plans.

We saw all staff were involved in the process of carrying out audits. Action plans were produced with staff responsible for completing these and timescales. Following a recent medication error, we saw the service had developed a new depot medication (long-acting injectable medication) audit that was completed monthly for every patient prescribed this medication. A weekly medication checklist had also been developed and we saw good compliance for completing this.

The health and safety committee produced a governance report every 3 months, which provided evidence of the actions the service had taken, as well as ongoing monitoring of patient and staff safety. We saw recommendations and requirements from the service's previous Healthcare Improvement inspection report were included in the report.

The service manager told us that the provider's quality assurance advisor and health and safety advisor visited the service every year. They carried out an internal review and monitored the service's progress, highlighting any recommendations for improvement.

The provider held regional clinical governance meetings every 3 months, which senior managers of the service attended. This provided an opportunity to share information, learn from incidents and implement additional governance monitoring.

The service had an up-to-date fire risk register and we saw appropriate fire safety equipment and signage in place.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or a major incident.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. The service had a quality improvement plan in place that recorded a review of the previous year's improvement objectives and whether these had been achieved. We saw improvement activities had been identified for 2025–2026, along with actions to be taken or being considered to implement improvements. Some examples included:

- improvements to the internal and external environment
- increasing patient involvement in service development and patient activities, and
- staff development and the introduction of staff champions (medication and safeguarding).

What needs to improve

While a legionella (water-borne bacteria) risk assessment had been carried out, we saw that some of the actions required were still outstanding (requirement 2).

While the service's quality improvement plan did include areas of improvement, it could be further developed with improvements identified through:

- audits
- complaints
- incident reviews, and
- patient feedback.

Timescales, completion dates and a mechanism to monitor planned improvements would allow the service to continually evaluate its performance, monitor actions and demonstrate where improvements are being made. We will follow this up at future inspections.

Requirement 2 – Timescale: by 19 August 2025

- The provider must action the findings of legionella risk assessment and ensure a legionella management plan and checks on water outlets and storage tanks are in place.

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 and the staff described the provider as a good employer.

Patient care information must be easily accessible in patient care records. National infection prevention and control procedures must be followed. Patient care plans should be accessible to patients and in easy-read format.

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. We did not request a self-evaluation from the service before the inspection.

The environment was clean and well maintained. Cleaning schedules were in place and up to date. We saw the appropriate cleaning products and solutions used, including chlorine-based products for sanitary fixtures and fittings. All cleaning materials and equipment were stored in appropriate areas, with limited access for staff only. We saw linen was stored and managed in line with the *National Infection Prevention and Control Manual*. The service had a good supply of personal protective equipment, such as aprons and gloves.

During our inspection, we saw the team working well together with the patients. The staff we spoke with showed care and compassion, as well as specialist knowledge for delivering care related to brain injury rehabilitation. We saw one instance where a patient was becoming quite angry and frustrated. The staff nurse dealing with this displayed a great deal of patience and understanding, which led to a positive outcome for the patient.

We had the opportunity to speak with members of the therapy team. They reported that they enjoyed their job and that ‘no day was the same.’ One member of the team that we spoke with was a student on placement who was very enthusiastic about the hospital as a learning experience. They told us they felt it had been a very worthwhile experience.

As part of our inspection, we asked the service to share an anonymous staff survey. Of those who responded, 92% of staff said they would recommend the organisation as a good place to work and 65% said they were able to influence how things were done in the organisation. Some comments from the survey included:

- ’I enjoy my job and would recommend the service as an excellent place to work.’
- ‘The clinical and support teams are great. Seeing positive outcomes for patients makes this a good place to work.’
- ‘Any feedback or suggestions I have made have been considered and some implemented.’
- ‘I am able to influence how things are done in the organisation through my contributive feedback in a periodic survey sent to staff.’

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

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

Some members of staff were foreign nationals. We saw that the service made sure that their visas were in-date, which allowed them to work in the United Kingdom.

We reviewed three patient care records and found a wide range of assessments, care plans and risk assessments in place. The patient care records were person-centred and focused on the goal of maintaining or regaining their independence. We saw evidence of multidisciplinary working, engagement with the community support and carer input.

We reviewed reports from patient multidisciplinary team meetings and found these contained detailed and comprehensive progress reports from a variety of clinicians providing input into a patient’s care, including:

- a review of care plans
- engagement with therapies
- physical health monitoring and medication, and
- risk assessments.

We saw that feedback from patients and their carers was also included.

We observed one mealtime. During this, we saw that each patient had the opportunity to choose their meal and where they wished to eat it. We saw that some patients chose to dine in the communal areas and others in their room. Patients told us they enjoyed the food and said the service accommodated their dietary preferences.

During our inspection, we spoke with a number of patients and their carers. They described mixed experiences of health and care provided in the service. Family members were invited to attend 3-monthly clinical meetings where they were able to discuss concerns and plans. Patients and carers told us they were also able to raise concerns out with this time directly with staff. Overall, people described the staff as caring and kind and felt safe in the environment. Comments included, 'I am very happy here. They are my family'.

What needs to improve

During our inspection, we found that patient information was not stored centrally in the patient care records. For example, while patient care plans and continuation (progress) notes were stored in an electronic system, multidisciplinary team information was stored separately on an electronic hard drive. Some staff we spoke with were unable to tell us where members of the multidisciplinary team would record their therapeutic activity sessions, as this was recorded in a different section of the electronic system. Some staff also reported difficulties in identifying where documents were stored in this system. This could lead to patient information being missed and cause confusion for staff, increasing the risk to patients (requirement 3).

During our inspection, we observed staff members cleaning and re-using single-use equipment, such as medicine cups and syringes. This is not compliant with national infection and control guidance. This was previously reported in our September 2023 inspection (requirement 4).

Each patient had different care plans in place to support their care needs in achieving their rehabilitation and we saw patients were involved in the development of these. However, patient care plans were all stored electronically in the service's electronic system and patients could not easily access them. We discussed the benefit of patients having access to their care plans and in an easy-read format, where appropriate with the ward manager and service manager (recommendation b).

The patients and carers we spoke with told us they had benefited from rehabilitation interventions from a range of allied health professionals. However, some patients said that therapy sessions did not always take place as

planned. For example, while occupational therapy was planned twice a week, one patient told us, ‘But that never happens.’ We were also told nursing and rehabilitation support workers could be more proactive at engaging service users in day-to-day activities and promoting independence, one patient told us, ‘They could push you more to be get better.’ We will follow this up at future inspections.

Requirement 3 – Timescale: by 19 August 2025

- The provider must improve the standard of record keeping in patient care records to ensure that they are easily accessible to all staff delivering patient care.

Requirement 4 – Timescale: immediate

- The provider must ensure that appropriate procedures are carried out for the prevention and control of infection.

Recommendation b

- The service should ensure that care plans are accessible to patients and developed in easy-read format for patients to have a better understanding of their treatment goals and progress.

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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