Healthcare Improvement Scotland | Inspections and reviews
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# Unannounced Inspection Report: Independent Healthcare

**Service:** Graham Anderson House, Glasgow

**Service Provider:** The Disabilities Trust

28–29 July 2026

NHS SCOTLAND

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# Contents

# 1 Progress since our last inspection

## What the provider had done to meet the requirements we made at our last inspection on 21 January 2026

### Requirement

*The provider must ensure that all staff are aware of, and working to, their job description, roles and responsibilities to ensure the co-ordination of patient care is efficient and effect.*

### Action taken

All staff had received a job description specific to their role in the service. We saw this had supported staff to better understand their role and responsibilities' and work together to deliver safe and effective patient care. **This requirement is met**.

### Requirement

*The provider must ensure all staff receive an annual appraisal to review their performance in the role and consider learning and development needs.*

### Action taken

The service maintained a record for all appraisals on an electronic platform and could evidence that all staff received these. **This requirement is met**.

### Requirement

*The provider must ensure all relevant staff receive training relevant to their role and responsibilities.*

### Action taken

The service used an electronic platform to record and monitor all staff training. We received a training compliance report that demonstrated staff had completed mandatory training requirements, including face-to-face training, such as basic life support (BLS). **This requirement is met**.

### Requirement

*The provider must ensure that quality assurance audits are carried out consistently and effectively identify issues in a timely manner.*

### Action taken

The service had implemented an audit tracking tool that identified the audits to be completed each month, as well as the member of staff responsible for completing audits. The tracker also identified the action plans and the staff responsible for implementing those actions. **This requirement is met**.

### Requirement

*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.*

### Action taken

The service had introduced a standard operating procedure to guide staff in all processes in the management of controlled drugs. The service evidenced that medication competencies had been completed for all staff and that a contract and process was in place for the safe disposal of medications. **This requirement is met**.

### Requirement

*The provider must arrange safe destruction of medication when it is no longer required.*

### Action taken

Arrangements were in place for safe destruction of medication. **This requirement is met**.

### Requirement

*The provider must improve the standard of recordkeeping in patient care records to ensure that they are complete, consolidated, are easily accessible to all staff delivering patient care and include:*

*(a) The date and time of every consultation with, or examination of, the service user by a health professional and the name of that health care professional*
*(b) The outcome of that consultation or examination*
*(c) Details of every treatment provided to the service user including the place, date and time that treatment was provided and the of the health care professional responsible for providing it and*
*(d) Every medication ordered for the service user and the date and time at which it was administered or otherwise disposed of.*

### Action taken

The service had developed a standard operating procedure for the electronic platform used to record patient information. Staff had received training on how to use the systems effectively and in line with the policy. We saw patient information was stored centrally on one electronic platform that was accessible for all staff. From the patient care records we reviewed, we found patient care records contained comprehensive information and were electronically signed and dated by the appropriate staff member. **This requirement is met**.

### Requirement

*The provider must ensure there are effective systems in place to make sure staff follow policies and procedures for managing deteriorating patients.*

### Action taken

The service had a 'Recognising Deterioration in Health' policy in place. Following the Healthcare Improvement Scotland inspection carried out 21 January 2026, staff were given a copy of the policy and asked to confirm they had read and understood it. We saw the majority of staff had also completed e-learning modules for recognising and responding to early warning signs of patient deterioration. The service had also developed a pathway for staff to escalate concerns and additional support from senior staff where necessary. We saw the service had also implemented a wellbeing clinic to monitor and review patient's physical wellbeing. **This requirement is met**.

## What the service had done to meet the recommendations we made at our last inspection on 21 January 2026

### Recommendation

*The service should ensure that all staff meetings have a set agendas and that minutes include actions and responsibilities.*

### Action taken

All staff meetings had set agendas. These meetings were minuted and included action plans with staff responsibilities identified.

### Recommendation

*The service should ensure that learning from incidents is used to improve systems and processes and that staff are fully involved and informed in this process.*

### Action taken

The service used an electronic platform to report and review incidents. We saw evidence that incidents were appropriately reviewed and discussed at clinical governance meetings, with a range of staff members in attendance. The service manager maintained a 'lessons learned' folder, providing evidence that learning from incidents had been identified, documented and shared with staff.

### Recommendation

*The service should ensure results from audits are developed into action plans to create a cycle of continuous improvement.*

### Action taken

From the audits we reviewed, we saw identified actions were recorded on the audit tracking tool and staff had been identified to implement any necessary actions.

### Recommendation

*The service should ensure the induction process is implemented consistently.*

### Action taken

The service used an electronic platform for staff induction. We saw evidence that the induction booklet had been reviewed and updated since our last inspection. New staff were given a role-specific induction checklist. The induction was carried out over 2 weeks and the checklist was signed and returned to their manager to evidence completion.

# 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 28 and Wednesday 29 July 2026. We spoke with a number of staff, service users and carers during the inspection. We received feedback from 56 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 three inspectors and a pharmacist.

## 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 provider had a clear vision and strategic plan with measurable objectives to measure its performance and to support continuous improvement. Governance and leadership structures helped staff to deliver care and meet the needs of patients.<br><br>Staff communication and engagement should be improved.<br><br>The service should develop a system to measure its local aims and objectives and share its progress with staff, patients and carers to demonstrate continuous improvement. | ✓ Satisfactory |
| **Implementation and delivery** | *How well does the service engage with its stakeholders and manage/improve its performance?* |
| The service used a variety of methods to gather patient feedback. Family and carer support was in place. The service actively participated with external stakeholders and brain injury networks. Staff training was completed and appraisals were carried out. Risk management and quality assurance processes, including an audit programme and quality improvement plan helped the service to deliver person-centred care. A duty of candour report was published every year.<br><br>Carer feedback should be reintroduced. Staff surveys should be reviewed and fed back to staff. Policies and procedures should be regularly reviewed and updated. Staff should be made aware of and offered the opportunity attend debriefs following an incident. Processes for managing adults with incapacity must be improved. The quality improvement plan and audit tracker could be improved to demonstrate a continuous cycle of improvement. | ✓ Satisfactory |

| Results | *How well has the service demonstrated that it provides safe, person-centred care?* |
|---|---|
| **Summary findings** | **Grade awarded** |
| The environment was clean. Patient care records were comprehensive and fully completed. Recruitment processes showed staff had been safely recruited and ongoing professional monitoring was in place.<br><br>Appropriate COSHH signage must be displayed in areas where hazardous substances are stored. The sluice area should be kept tidy and appropriate signage should be displayed for the storage of hazardous substances. | ✓ 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 one requirement and 10 recommendations.

| Direction | |
|---|---|
| **Requirements** | |
| | None |
| **Recommendation** | |
| **a** | The service should develop a system to measure its progress in achieving its local aims and objectives and share this information with staff, patients and carers (see page 17).<br><br>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** | |
| | None |

| Implementation and delivery (continued) | |
|---|---|
| **Recommendations** | |
| **b** | The service should strengthen communication and engagement with staff to ensure staff feel supported in their roles, promote a positive culture and improve the visibility of senior leaders in the service (see page 20).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **c** | The service should reintroduce carer feedback surveys and 3-monthly newsletters to support engagement with family members and carers (see page 24).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **d** | The service should ensure that staff surveys are reviewed and results fed back to staff (see page 24).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **e** | The service should ensure that policies and procedures are regularly reviewed to ensure they remain up to date (see page 29).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11 |
| **f** | The service should ensure that all staff are aware of and offered the opportunity to attend debriefs following incidents (see page 29).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **g** | The service should review its processes for section 47 certification to ensure patient's needs and circumstance are informed by the specialist multidisciplinary team and discussed with their next of kin (see page 29).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.15 |

| Implementation and delivery (continued) | |
|---|---|
| **Recommendations** | |
| **h** | The service should further develop its audit tracking tool to record when actions identified through audits have been addressed and improvements have been implemented (see page 32).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |
| **i** | The service should further develop its quality improvement plan (see page 32).<br><br>Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19 |

| Results | |
|---|---|
| **Requirement** | |
| **1** | The provider must ensure that appropriate COSHH signage is displayed in areas where hazardous substances are stored (see page 35).<br><br>Timescale – by 28 October 2026<br><br>*Regulation 3(a)*<br>*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |
| **Recommendation** | |
| **j** | The service should ensure the sluice room is kept organised and tidy and ensure staff have easy access to clinical handwash facilities (see page 35).<br><br>Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.24 |

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 requirement 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 provider had a clear vision and strategic plan with measurable objectives to measure its performance and to support continuous improvement. Governance and leadership structures helped staff to deliver care and meet the needs of patients.**

**Staff communication and engagement should be improved.**

**The service should develop a system to measure its local aims and objectives and share its progress with staff, patients and carers to demonstrate continuous improvement.**

#### *Clear vision and purpose*

The service is part of a national charity organisation that provides specialist neurological rehabilitation for patients with acquired brain injuries and complex neurological needs.

A core set of values underpinned the provider's vision of 'a world where life after brain injury is a life well lived.' This was clearly stated on the provider's website and displayed in the service for staff, patients and carers to view.

Key aims and objectives set out the goals of the provider's strategic vision in its 8-year (2022–2030) strategic plan. The objectives included the following:

- Build positive, specialist and co-produced sustainable services, reaching as many people as possible.
- Deliver leading-edge clinical practice and thinking around brain injury, continuously improving delivery for ourselves and others.
- Drive social action around brain injury and ensure that more people have their needs met, in a way of their choosing.

Key performance indicators (KPIs) were used to measure the provider's performance against its strategic aims and objectives. The provider also

published an annual report on its website each year, showing its achievements, performance and progress towards achieving its strategic vision.

The service had its own statement of purpose which included the provider's mission statement 'inspired by the potential of the disabilities, we are working in partnership to provide the highest quality if service' alongside local aims and objectives specific to the service. We saw that this was displayed on the noticeboard at the entrance to the service. Examples of objectives included:

- Provide care which is person centred and carried out in a manner which is flexible, attentive and non-discriminatory.
- Respect the people we support rights to independence, dignity, privacy, fulfilment and the rights to make informed choices and to risks.
- To involve staff and the people we support in determining quality.
- To manage and implement a formal programme of staff planning, selection and recruitment, training and personal development to enable the people we support care needs to be met.

We were told the service measured its performance against these objectives through a range of quality assurance activities, including audits, patient feedback, reporting systems and clinical governance meetings.

The service had also set out additional objectives for 2025-2026 that were detailed in its service development plan. Some examples included:

- increase participation for the people we support
- maintain good compliance with standards of external regulators, and
- maintain the quality of the environment to a high standard.

We saw each objective had set out key tasks, responsibilities and identified resources required to achieve these.

### What needs to improve

While the service had a local statement of purpose and defined local aims and objectives, we saw no evidence that progress towards achieving these objectives were measured or evaluated. It would be beneficial for the service to demonstrate its progress in achieving these objectives with staff, patients and carers. This would help staff, patients and carers understand how the service measures its success and drives continuous improvement (recommendation a).

- No requirements.

### Recommendation a

- The service should develop a system to measure its progress in achieving its local aims and objectives and share this information with staff, patients and carers.

### *Leadership and culture*

The service had a diverse workforce of health and social care staff, including:

- a brain injury counsellor
- a physiotherapist
- clinical psychologists and neuropsychologists
- consultant psychiatrist
- occupational therapists
- nurses
- rehabilitation support workers, and
- speech therapists.

A variety of ancillary staff supported the clinical staffing team, including:

- catering
- housekeeping, and
- maintenance.

The service leadership structure included a service manager and assistant manager, who had overall responsibility and oversight of the service. They had support in delivering safe care for patients from:

- a maintenance manager
- lead allied health professionals
- lead support workers, and
- senior clinical staff.

Governance systems and processes were in place to help staff deliver safe care and support improvement in the service, including:

- a monthly audit programme
- a range of staff meetings
- health and safety meetings
- incident management systems
- monthly clinical governance meetings
- monthly regional governance meetings, and
- weekly management meetings.

The monthly clinical governance meeting followed a standard agenda covering a range of governance issues. A governance report was produced every 3 months and discussed at the provider's regional operational team meetings, which the service manager also attended. This allowed the service manager to keep up to date with changes in the organisation, have access to peer support and share service updates with the provider.

All staff groups attended a daily handover meeting in the morning. Each patient's care and progress was discussed, as well as any incidents that had occurred overnight. We saw that a schedule was given to support staff at the start of each shift that identified the patients they were responsible for supporting. This included details of each patient's specific care needs, any planned outings and any identified risks. This helped make sure staff were aware of the support required and any risks that may require additional assistance from staff.

Staff completed a weekend report and shared this with the service manager. The weekend report gave the manager an overview of each patient, identified any accidents or incidents that had occurred over the weekend and any staffing issues that required following up.

We saw evidence of appropriate staffing levels to support safe delivery of patient care. We were told that staffing levels would increase depending on service user needs, if required. This included the use of bank and agency staff.

Senior managers attended the weekly management meeting, along with medical staff and members of the multidisciplinary team. As well as funding or any other current issues, this meeting would discuss:

- all new referrals
- any admissions
- discharges
- outpatients, and
- the waiting list.

We saw that the senior clinicians and support worker team leads would share information from this meeting with the local teams.

The service leadership structure included a service manager and assistant manager, who had overall responsibility and oversight of the service. They had support in delivering safe care for patients from:

- a maintenance manager
- lead allied health professionals
- lead support workers, and
- senior clinical staff.

We saw the provider developed and promoted a 'freedom to speak up whistleblowing' policy for patient and staff safety. We were told the service had an open-door policy for all staff to have access to the senior team.

The service provided opportunities for staff development, leadership and continuous professional development. A learning management platform was available on the provider's intranet system, which offered modules for continuous professional development and leadership. We saw three members of staff had recently been accepted onto Scottish Vocational Qualification (SVQ) level 3 and 4 health and social care programmes. We were told training was available for team leaders to support them with their line management responsibilities to allow them to supervise, support and manage support workers.

The majority of staff completed our survey told us that the service had a positive leadership and culture in the service. Examples included:

- ‘Leadership is supportive and visible.’
- ‘Very approachable and supportive.’
- ‘The team have worked really hard… to improve communication and support each other through challenging situations.’

### What needs to improve

We spoke with a range of staff members during our inspection. Some staff told us communication as good and told us they felt that management supported them well. However, other staff told us they found a lack of communication in the service and they did not always feel supported when raising concerns. Comments we received from our survey included:

- ‘Lack of positive leadership…lack of encouragement and support… staff are reluctant to speak openly or raise concerns.’
- ‘…Staff do not always feel supported, listen to or that concerns raised result in meaningful action or feedback.’
- ‘…Greater investment in leadership, people management and communication…would help promote trust, collaboration and staff engagement.’

Some staff also reported that senior leaders were not visible in the service. (recommendation b).

- No requirements.

### Recommendation b

- The service should strengthen communication and engagement with staff to ensure staff feel supported in their roles, promote a positive culture and improve the visibility of senior leaders 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 used a variety of methods to gather patient feedback. Family and carer support was in place. The service actively participated with external stakeholders and brain injury networks. Staff training was completed and appraisals were carried out. Risk management and quality assurance processes, including an audit programme and quality improvement plan helped the service to deliver person-centred care. A duty of candour report was published every year.**

**Carer feedback should be reintroduced. Staff surveys should be reviewed and fed back to staff. Policies and procedures should be regularly reviewed and updated. Staff should be made aware of and offered the opportunity debriefs following an incident. Processes for managing adults with incapacity must be improved. The quality improvement plan and audit tracker could be improved to demonstrate a continuous cycle of improvement.**

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

- rehabilitation at the service
- staff working in the service
- the environment and facilities available, and
- the local community.

The service had a patient and carer participation strategy in place. This described the aims of patient and carer involvement and the approaches used to promote learning and improvements in the service. We saw this was displayed on the noticeboard at the entrance of the service.

A variety of methods were used to collect patient feedback, including:

- a suggestion box in the reception area of the service
- patient feedback surveys, and
- patient forum meetings.

Patient surveys were carried out every year and we saw results were reported back to patients in an easy read format. This information was also sent to the provider and improvement plans were developed. We saw this was then discussed in previous patient forum meetings. At the time of our inspection, the service was developing the improvement plan for 2026.

We saw recent examples of activities the service provided for patients, such as:

- a sports day
- an outing to a car show, and
- world cup themed activities.

We were told of a planned family fun day for August 2026. We were also told that ex-patients had volunteered to return to the service to speak with patients and shared their lived experience. The service also told us that the occupational therapist had recently supported an ex-patient to present their patient journey at a Head Injury Information Day conference held in Glasgow.

The clinical leads and the brain injury counsellor held a family support group for families and carers. The support group encouraged family members to support each other and share educational sessions about caring for a family member who had experienced a brain injury.

Families and carers could provide feedback directly to the service or through the suggestion box. We were told that families were contacted, where appropriate, after a patient's period of leave from the hospital to ask how the patient had managed during their time away from the service. Family members could also provide feedback at multidisciplinary team review meetings.

The service actively engaged and worked collaboratively with external stakeholders. The service told us they had good working relationships with:

- health and social care partnerships
- local community organisations and amenities
- local GP services, and
- NHS services.

This helped to support the delivery of patient care and facilitated patients' rehabilitation and reintegration into the community.

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.

A staff recognition programmes was in place. A recognising excellence award was held every 6 months, which would highlight an individual or a team. A voucher would be given to the winner. A monthly appreciation award was also in place where staff would vote for each other, with the winner receiving chocolates or flowers.

The majority of staff who completed our survey told us they were able to influence how things are done in the organisation. Comments included:

- ‘They give us loads of platforms to be able to speak up.’
- ‘Suggestions are listened to and considered.’
- ‘I am able to speak up and make suggestions.’

### What needs to improve

During our inspection, we were told the service previously carried out carer surveys and produced a 3-monthly newsletter for patients. However, these had not been carried out for some time (recommendation c).

A range of staff meetings were held and staff had opportunities to provide feedback. However, the results of the December 2025 staff survey had not been reviewed or fed back to staff. We were also told that the service had previously used a questionnaire asking staff to identify three things they would improve for patients, the service and themselves. However, this questionnaire had had not been carried out recently (recommendation d).

In line with recommendation b made earlier in this report, not all staff who completed our survey were positive about their ability to influence the organisation. Some staff also told us:

- 'I feel unable to influence how things are done…'
- 'The organisation is not proactive with any feedback on any improvement suggestions.'
- 'I feel I am unable to contribute to how things are planned or discussed…emails not read and no feedback from management.'

### Recommendation c

- The service should reintroduce carer feedback surveys and 3-monthly newsletters to support engagement with family members and carers.

### Recommendation d

- The service should ensure that staff surveys are reviewed and results fed back to staff.

### *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 of certain events or incidents occurring in the service.

The service had a range of policies and standard operating procedures, including those for:

- consent
- freedom to speak up whistleblowing (detailing how staff could raise concerns about patient safety or practice in the service)
- health and safety
- infection prevention and control
- medicine management, and
- prevention and management of falls.

To support version control and accessibility, policies were available electronically on the staff intranet.

The service had an incident management policy in place, which defined incidents and set out the process for reporting and how it should be managed. 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, and
- incident review and investigation.

We reviewed two incidents during our inspection and could see that they had been recorded, investigated and any learning or actions put in place. We saw that learning from incidents was shared during staff meetings and were told verbal discussion around learning took place at morning safety briefs.

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.

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 provider's clinical governance and human resource teams would review complaints centrally and allocate them to the appropriate person for investigation. We reviewed two complaints and saw they had been managed in line with the service's complaint policy.

Effective processes and procedures were in place to make sure the environment was safe, including appropriate infection prevention and control measures. These measures were carried out in line with the service's infection prevention and control policy. The policy was in line with national infection prevention and control guidance. It described the precautions in place to prevent patients and staff from being harmed from avoidable infections. Precautions included:

- hand hygiene practice
- the management of laundry, sharps and clinical waste, and
- the use of personal protective equipment (such as disposable aprons, gloves and face masks).

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. This assessment considered the physical and emotional needs of the patient and whether the service met the needs of the patient.

A range of clinical specialists delivered patients' care. We saw that each patient was reviewed at multidisciplinary team meetings over their stay. During these meetings, each professional contributed an assessment of the patient's needs and progress towards their rehabilitation goals. We found that comprehensive multidisciplinary reports were produced to:

- evidence patients' progress
- inform care planning, and
- support decision-making regarding their ongoing treatment and rehabilitation.

Patients were provided a timetable of scheduled activities. This included social activities and therapeutic sessions with staff, such as physiotherapy and occupational therapy.

The service had recently implemented a new ward round process, which commenced during our inspection. The ward round was led by the ward manager, specialty doctor, and medical secretary. We were told that patients invited to attend the ward round received a letter in advance of their appointment. This allowed them to prepare any issues or questions they wished to discuss. Support staff provided patient support to attend these meetings. Staff told us that patient and staff feedback would be gathered to review the effectiveness of the new ward round to identify any further improvements.

We saw that patients who were admitted under the Mental Health (Care and Treatment) (Scotland) Act 2003 had all the required paperwork in place for their 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 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 plan.

While in the service, patients were temporarily registered with a local GP practice. 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. The service did not stock medication. The patient's local GP prescribed medication following recommendations from medical staff in the service.

We saw systems and processes were in place to make sure that medicines, including controlled drugs were managed safely in the service. We saw the controlled drug registers were organised, with administration and checks clearly documented. Controlled drug checks were carried out twice daily during shift changes. We saw that two senior members of staff also carried out a weekly controlled drugs audit.

A recruitment policy was in place to support safe recruitment of staff. Appropriate background checks were obtained for staff, including:

- Disclosure Scotland Protecting Vulnerable Groups (PVG) updates
- evidence of qualifications
- identification checks, and
- two references.

All staff had access to a comprehensive online platform for learning and development, with a range of training suitable for their role and responsibilities at a time convenient for them. We saw most staff were up to date with mandatory training, including training for:

- conflict management
- dysphasia awareness
- epilepsy awareness
- infection prevention and control, and
- safeguarding children and young people.

We saw that staff received face-to-face training for:

- moving and handling
- physical restraint and conflict management, and
- recognising and managing deterioration.

The service had sourced a new training provider to provide face-to-face training for immediate life support and we found that all staff were up to date with this training.

An induction policy and role-specific induction handbooks supported new staff joining the service. We saw evidence of induction checklists and review processes for new staff.

A 'Being our Best' policy was in place to support staffs continued development. An online platform was used to record and monitor annual appraisals and one-to-one meetings carried out every 3 months for all staff. We saw evidence that these were carried out and recorded in line with the policy.

### What needs to improve

While the service had a variety of policies in place, some required to be reviewed and updated. A process for the revision and update of policies should be developed. The service told us that the provider's quality assurance team was reviewing some policies at the time of our inspection (recommendation e).

Post-incident de-briefs help a service to identify and address:

- any physical harm caused
- ongoing risks, and
- the emotional impact on patients and staff.

This also provides an opportunity for staff to give their view of the event and understand what happened. We reviewed the new structure in place at the service for clinical supervision. We were told all staff were offered supervision and access to debrief sessions with the brain injury counsellor after challenging incidents, such as violence or aggression from a patient. However, some staff we spoke with were not aware that this support was available (recommendation f).

The Adults with Incapacity (Scotland) Act 2000 provides a legal framework to protect adults who cannot make decisions for themselves due to mental or cognitive impairment. We found that where appropriate, patients had a valid

Section 47 certificate in place. This provided the service with the legal authority to deliver certain necessary medical treatment where patients lacked the capacity to consent. We saw the patients' GP was the lead clinician for dealing with section 47. However, the service had a range of multidisciplinary clinicians who were involved in the assessment, care and treatment of patients. A team approach and a review of internal processes would provide a more holistic consideration of patients' needs and circumstances, when making decisions about care and treatment. This should also be discussed with patient's next of kin or welfare guardian (recommendation g).

- No requirements

### Recommendation e

- The service should ensure that policies and procedures are regularly reviewed to ensure they remain up to date.

### Recommendation f

- The service should ensure that all staff are aware of and offered the opportunity to attend debriefs following incidents.

### Recommendation g

- The service should review its processes for section 47 certification to ensure patient's needs and circumstances are informed by the specialist multidisciplinary team and discussed with their next of kin.

### *Planning for quality*

The maintenance team oversaw all non-clinical services in the service. An external company oversaw all maintenance contracts for the organisation. The external company used an electronic platform to monitor and schedule when maintenance and servicing was due, including that for the:

- boiler
- electrics
- gardens
- gas, and
- oxygen.

The service's in-house maintenance and housekeeping team completed a programme of daily and weekly checks.

A detailed contingency plan was in place for major incidents that would affect the running of the service and impact on patient care. Arrangements were documented for staff to follow in case of such events.

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:

- infection control
- legionella (a water-based bacteria) risk assessment
- physical aggression, and
- staffing.

The service had an up-to-date fire risk assessment, appropriate fire safety equipment and signage in place. The weekly fire alarm test was carried out during our inspection. We saw up-to-date servicing checks for electrical safety and patient equipment.

Different staff members carried out a programme of clinical and non-clinical audits to help the service 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.

The service had implemented an audit tracking tool which identified the audits to be completed each month. This was updated after audits were completed

and used to monitor compliance with the service's audit programme. This helped to provide oversight of audit activity and make sure audits were completed in agreed timescales.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions to improve the quality and safety of care. We reviewed the service's quality improvement plan, which included the objectives set out for the previous year and whether these had been achieved. It also provided details of the inspection grades awarded at the service's previous Healthcare Improvement Scotland inspection. The service had set out its new objectives for 2026–2027. We were told some these objectives remained the same to previous year's and this was where the service had identified improvement work that was ongoing. The improvement plan also identified improvements for:

- internal and external environment
- patients (activities, service development and resources), and
- staffing (development and service improvement).

### What needs to improve

The service's audit tracking tool should be further developed to record when actions identified through audits have been completed. This would help to demonstrate that improvement activities have been implemented and give assurance that identified issues have been addressed (recommendation h).

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

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

Documented timescales, completion dates and a mechanism to monitor planned improvements in the quality improvement plan would allow the service to continuously evaluate its performance, monitor actions and demonstrate where improvements are being made (recommendation i).

■ No requirements.

### Recommendation h

- The service should further develop its audit tracking tool to record when actions identified through audits have been addressed and improvements have been implemented.

### Recommendation i

- The service should further develop its quality improvement plan.

## 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. Patient care records were comprehensive and fully completed. Recruitment processes showed staff had been safely recruited and ongoing professional monitoring was in place.**

**Appropriate COSHH signage must be displayed in areas where hazardous substances are stored. The sluice area should be kept tidy and appropriate signage should be displayed for the storage of hazardous substances.**

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

We spoke to a patient during the inspection process who told us staff had supported them to engage in activities that they had previously enjoyed.

The environment was clean and corridors and rooms were free from clutter. However, some areas required refurbishment. The service manager told us they were awaiting approval for some internal refurbishment. We saw this was included in the service's quality improvement plan.

We saw cleaning taking place during our inspection. Housekeeping staff used appropriate chlorine-based cleaning products for sanitary fixtures and fittings. All mops and mop heads were colour-coded and would be laundered after each use. We saw cleaning schedules in bathrooms and service users' rooms, which would be cleaned daily. All cleaning materials and equipment were stored in appropriate areas, with limited access for staff only. The service had a large laundry facility where all linen was laundered at appropriate temperatures. The machines were maintained in line with national disinfection requirements. Personal protective equipment (such as aprons and gloves) was readily available throughout the service, with additional stock located in ward store cupboards.

We reviewed five care records as part of the inspection process. All five care records reviewed included a variety of care plans, a wide range of assessments, and risk assessments in place that demonstrated a person-centred approach.

We saw evidence of multidisciplinary working. Care plans had a traffic light system in place (amber identified that the review of care plan is approaching while red indicated that the care plan review was overdue). All care plans we reviewed were up to date. The care plans reviewed demonstrated that each patient's views, preferences and wishes had been discussed and were considered during the care planning process. Consent to treatment documentation was available for each patient where applicable and stored under mental health documentation. From the patients' clinical documents that we reviewed, we were able to see that all required documentation was complete, up to date and reflected their current legal status.

The five 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.

The service manager kept a record of when staff checks, including registration and PVG's were due to be reviewed. An allocated administration staff member reviewed this each month.

Some members of staff were foreign nationals. We saw that the service had processes in place to make sure visas and right-to-work documentation remained valid and up to date. This helped make sure that these staff members remained legally entitled to work in the United Kingdom.

The service manager maintained a spreadsheet to support regular checks of professional registrations, including those with the:

- General Medical Council (GMC)
- Health and Care Professions Council (HCPC), and
- Nursing and Midwifery Council (NMC).

This helped make sure that staff remained appropriately registered.

### What needs to improve

During our inspection, we saw cleaning materials and equipment were stored in appropriate areas, with limited access for staff only. However, these areas did not have appropriate COSHH (the control of substances hazardous to health) signage in place (requirement 1).

We found that the ward sluice room cluttered and disorganised. This made it difficult to clean the environment effectively and access to the clinical hand wash basins was obstructed (recommendation j).

### Requirement 1 – Timescale: by 28 October 2026

- The provider must ensure that appropriate COSHH signage is displayed in areas where hazardous substances are stored.

### Recommendation j

- The service should ensure the sluice room is kept organised and tidy and ensure staff have easy access to clinical handwash facilities.

## 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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