

Action Plan

Service Name:	Revive MS Support
Service number:	02672
Service Provider:	Revive MS Support
Address:	Moorpark Court, 29 Dava Street, Glasgow, G51 2JA
Date Inspection Concluded:	24 and 25 August 2026

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Requirement 1. The provider must develop a cleaning schedule which includes details on cleaning products, processes and records of completion of cleaning	Implement a documented cleaning schedule immediately for all clinic areas. The schedule will specify the cleaning product and process for each task, cleaning frequency, arrangements for changing or cleaning mop heads, the frequency of deep cleaning, the responsible role and a record of completion. Completion records will be reviewed monthly and missed entries investigated and addressed. Evidence: Documented cleaning schedule has been developed and currently being implemented and reviewed accordingly. Please see photo attached.	Immediately being actioned	Facilities Manager

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Requirement 2. The provider must ensure that appropriate Control of Substances Hazardous to Health (COSHH) signage is displayed in areas where hazardous substances are stored	COSHH hazard signage has been displayed on the cleaning cupboard, kitchen cupboard, and laundry room where hazardous substances are stored, following a check of all storage areas. Signage will be checked as part of the six-monthly COSHH audit. Evidence: Signage now in place.	Immediately	Health and Safety Lead
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Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Recommendation a. The service should develop measurable key performance indicators to help monitor how well the service is being delivered	Develop and implement a monthly performance dashboard incorporating key service statistics and agreed performance targets. The dashboard will monitor safety, incidents, complaints, client feedback, documentation compliance, cancellations and capacity utilisation, with performance reviewed against target, variances investigated and corrective actions recorded through the service's governance process. Evidence: KPI definitions, baseline report, monthly dashboard and management minutes.	Dec 2026	Registered Manager/CEO

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Recommendation b. The service should ensure clients are informed of any changes made to the service as a result of their feedback	Establish a formal “You said, we did” feedback process to demonstrate how client feedback informs service improvement. Anonymised updates will be communicated through the reception TV display and the service website. Feedback received, actions taken and published updates will be reviewed quarterly to ensure the information remains accurate, relevant and up to date. Evidence: Feedback log, published updates and quarterly review record.	Dec 2026	Registered Manager/CEO
Recommendation c. The service should develop a documented check-in process to show that a review has been completed every time a client attends for hyperbaric oxygen therapy	Trial a brief, exception-based documented health check-in as part of the existing arrival and chamber-preparation process. At every attendance for hyperbaric oxygen therapy, trained staff will ask a standard set of concise questions about changes in health, medication and possible contraindications. Where no change is reported, staff will record confirmation on electronic record. Positive responses will be escalated to an appropriately qualified clinician under a written protocol, with the decision to proceed, delay or cancel treatment and any action taken recorded. The trial will assess completion, time taken, delayed starts, escalations and any missed check-ins before the final procedure is approved and implemented. Evidence: Trial check-in and update protocol accordingly with session recording, escalation processes and audit.	Dec 2026	Registered Manager

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Recommendation d. The service should develop a programme of regular audits to cover key aspects of care and treatment. Audits must be documented and improvement action plans implemented	Implement a rolling annual audit programme covering care records and consent, IPC, environmental cleaning, COSHH, documented HBO check-ins and personnel files. Each audit will define its owner, scope, sample, schedule, findings and corrective actions. Completion and sustained improvement will be verified through follow-up checks, with progress and outcomes reported through the Clinical Governance Team, SMT and board of Trustees Evidence: Annual audit calendar, approved audit tools and sampling plans, completed reports, corrective-action and closure records, and governance minutes confirming review of progress and outcomes.	Dec 2026	Registered Manager/CEO
Recommendation e. The service should develop and document a formal business contingency plan that sets out the arrangements for the continuity of care for clients, in the event of the service closing for any reason	Develop, approve and implement a business continuity and recovery plan covering unexpected closure, communication, clinical escalation, treatment interruption, access to essential records, utilities, IT or equipment failure, staffing arrangements and safe restoration of services. The plan will include clear responsibilities, a contact cascade, alternative service arrangements and annual scenario-based testing, with review following any incident. Evidence: Business continuity and recovery plan, current contact cascade, action log and closure records. Approved by the board of Trustees.	Dec 2026	Registered Manager/CEO

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Recommendation f. The service should obtain two references for new members of staff, in line with safe recruitment practices, and ensure that a signed volunteer agreement is in place between volunteers and the provider.

Update the recruitment policy and checklist so that two satisfactory references are obtained, verified and recorded before any new member of staff and volunteers starts work. Introduce a signed volunteer agreement, setting out the role, expectations, confidentiality and supervision arrangements, to be signed by every volunteer before they begin and held in their file. Compliance will be verified through the annual personnel file audit (Recommendation d) and reported through the service's governance process.
Evidence: Updated recruitment policy and checklist, references held on personnel files, volunteer agreement template and signed copies, and personnel file audit results.

Dec 2026

Registered
Manager/CEO

Name

Julie Dock

Designation

Clinical Lead/Registered Manager

Signature

Julie Dock

Date

16 / 10 /2026

In signing this form, you are confirming that you have the authority to complete it on behalf of the service provider.

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Guidance on completing the action plan.

- **Action Planned:** This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales** for some requirements can be immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- **Person Responsible:** Please do not name individuals or an easily identifiable person. Use Job Titles.
- Please do not name individuals in the document.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector for your inspection.

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