West Dunbartonshire HSCP Re-ablement Service
Support Service

Vale Centre for Health and Care
Alexandria
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Type of inspection:
Unannounced

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Service provided by:
West Dunbartonshire Council

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About the service

West Dunbartonshire HSCP Re-ablement Service provides a short-term service which supports people at home after a hospital stay, illness or injury. An integrated team, including carers, organisers, rehabilitation staff and therapists, works closely with individuals to help them regain independence and confidence with everyday tasks.

The service has recently merged with the hospital discharge team, who provide a more traditional homecare role. Where longer-term help is needed, the service helps people transition to other local resources and care options in-line with their goals and wishes.

The service operates from an office base in Alexandria and delivers care within the West Dunbartonshire local authority area. At the time of inspection, there were 79 people using the service.

About the inspection

This was an unannounced inspection which took place on 10, 11, 13 and 15 June 2025 between 11:00 and 19:30. The inspection was carried out by one inspector from the Care Inspectorate.
To prepare for the inspection we reviewed information about this service. This included registration information, information submitted by the service and intelligence gathered.

In making our evaluations of the service we:

- spoke with 11 people using the service and 4 of their family members
- spoke with 9 staff and management
- observed practice and daily life
- reviewed documents including the results of satisfaction surveys completed by staff
- spoke with two external professionals

Key messages

- People appreciated the support they received and felt more confident after leaving hospital.
- Some visits didn't happen as planned, which left people feeling anxious or at risk.
- Plans about how to support people weren't always clear or kept up-to-date.
- Staff felt able to speak with managers, but managers didn't always have enough time to provide regular support.
- Ongoing staff absences and unclear roles made it harder for the team to work well together.

From this inspection we evaluated this service as:

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

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

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

How well do we support people's wellbeing? 3 - Adequate

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

People spoke highly of the support they received, often describing carers as patient, encouraging, and supportive of their recovery, particularly after hospital discharge. Many valued the help with mobility and personal care, and this contributed to a sense of regained confidence. However, concerns were raised around the lack of consistency in carers. People told us this made it difficult to build relationships and feel fully at ease, which affected trust.

Timeliness of visits was a recurring theme. People expressed anxiety when carers arrived unexpectedly early or late, or when they were unsure if someone would come at all. This unpredictability led some individuals, particularly those with poor mobility, to attempt personal care alone, resulting in falls or near misses. We heard examples where people had dressed or gone to bed without scheduled support, compromising their safety and wellbeing. Some individuals experienced falls when attempting to mobilise unassisted and others made errors with medication, when trying to manage alone due to late or missed visits. This meant that people's health and safety was compromised.

Medication support was inconsistent, and this placed people at risk of harm. Several individuals requiring prompting or support with medication were observed struggling without sufficient guidance. Care plans lacked sufficient detail in how medication support was to be offered and what level of support people needed. Carers did not always check whether medication had been taken and recording in care diaries was often incomplete, making it difficult for managers and staff to identify concerns. This put people at risk.

(Please see requirement 1)

Falls management practices were inconsistent and raised serious concerns about falls risk awareness and follow-up procedures. Several falls were either not documented, or not communicated to management, resulting in missed opportunities to review care and provide reassurance or to reduce risk. Complaints from families further evidenced a pattern of poor communication when falls occurred. These failures compromised people's safety, delayed medical intervention where needed, and prevented timely updates to risk assessments and care planning.

(Please see requirement 2)

We witnessed additional risks caused by poor scheduling. Medication administration had been hindered due to staff being redeployed at short notice. Unplanned shift adjustments placed strain on carers and led to inconsistent support for people, with some visits occurring outside scheduled times.

(Please see area for improvement in section 'How good is our leadership.')

Carers reported that they previously worked in smaller teams, which helped build trust and enabled better tracking of changes in people's presentation. The current scheduling approach makes this more difficult and impacts the quality and continuity of care. Carers also said they lacked up-to-date guidance on how to support people, especially around personal preferences, goals and progress toward independence. This was

echoed by support workers, who found the lack of consistent note-taking by carers made it difficult to plan or reduce support appropriately.

While there were valued aspects of care, particularly in the quality of personal support, there are crucial issues which must be addressed in related to medication support, falls management, documentation and scheduling. These improvements require to be made to improve outcomes for people using the service.

Requirements

1.

By 10 October 2025, the provider must ensure people receive medication support that is safe and supports their health and wellbeing.

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

a) Ensure that people's need for medication assistance is assessed and reviewed to ensure that they receive the right level of support (prompt, assist or administer) to take their medication safely.

b) Medication records are accurate and assistance is correctly recorded.

c) Ensure that processes are in place to regularly assess staff practice and competency in medication management and in relation to medication recording.

d) Regularly audit medication records to identify any discrepancies.

This is to comply with Regulation 3 and 4 (1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and section 8(1)(a) of the Health and Care (Staffing)(Scotland) Act 2019.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that:

'Any treatment or intervention that I experience is safe and effective.' (HSCS 1.24)

2.

By 10 October 2025, the provider must ensure people receive high-quality support which keeps them safe from harm, through falls prevention that is tailored to each persons assessed level of required support, inline with best practice guidelines.

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

a) Staff receive training on moving and assisting and falls prevention and have their competency assessed.

b) Ensure all falls are recorded, evaluated and risk assessments are updated.

c) Address identified risks and ensure actions are communicated to, understood by and implemented by staff.

d) Make referrals to external health professionals when this is needed.

This is to comply with Regulation 3 and 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and section 8(1)(a) of the Health and Care (Staffing)(Scotland) Act 2019.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that:

'Any treatment or intervention that I experience is safe and effective.' (HSCS 1.24)

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where some important strengths were evident, but these were offset by weaknesses that need to be addressed to improve outcomes for people.

Leaders within the service were described by carers as approachable, visible, and responsive. Several staff gave specific praise for individual managers, describing them as supportive when issues were raised. This culture of informal support fostered trust and commitment across the team. However, despite the openness of the leadership team, formal supervision was inconsistent. Carers reported going months without one-to-one meetings with managers, limiting their ability to receive reflective feedback or raise concerns in a formal setting. This meant that opportunities were missed for professional development, which would improve the quality of service provided by carers.

(Please see area for improvement 1)

Workforce pressures significantly affected the service's capacity to function effectively. Carers described high workloads, particularly at weekends, which led to fatigue and a sense of burnout. Staff survey feedback echoed these concerns and highlighted the need for recruitment to alleviate strain. Although staff remained committed, the pace of work was unsustainable. This meant that staff were unable to work effectively due to workload pressures.

Scheduling presented further challenges. Carers reported that rota planning did not always account for the time needed to travel between visits or the complexity of care tasks. This led to rushed visits and in some cases to medication being delivered late. We also found examples of carers attending visits that had been cancelled in advance, indicating poor internal communication. These issues affected both the quality of care and people's trust in the service.

(Please see area for improvement 2)

The pressure on care organisers was evident. An administrative post remained unfilled, requiring organisers to take on multiple roles. This reduced their capacity to oversee day-to-day operations, manage changes to care plans and communicate effectively with the wider team. Critical information was not always passed on to service managers, and there were delays in actioning referrals for additional support. This meant that the quality of support people received was compromised.

We also identified issues with role clarity following the integration of hospital discharge staff. Carers expressed uncertainty about expectations, leading to confusion among people receiving care. One person, for example, had been encouraged by some staff to practise mobility exercises outdoors, while other carers were unsure whether this was part of the support plan. This meant that people were not getting a consistent approach towards reablement and reduced its effectiveness.

While the values and commitment of managers provided a strong foundation for the service, issues with scheduling, communication, and staff oversight needed further development. Areas for improvement have been identified to strengthen scheduling and ensure supervision is delivered consistently across the team.

Areas for improvement

1.

The service should establish regular and meaningful supervision for all staff groups and include competency checks within their quality assurance processes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state:

'I benefit from culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

2.

The service should implement regular scheduling reviews,, to ensure visit times align with people's preferred daily routines. The service should also ensure that the duration of visits aligns with the needs of each individual in order that people's support is not rushed.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state:

'My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.' (HSCS. 4.14) and

'My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.' (HSCS 1.23)

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate, where staffing arrangements were generally effective but required more consistent communication and coordination, to ensure the best outcomes for people and staff.

People using the service and external professionals valued the team's role in promoting independence. One health professional described the team as goal-oriented and focused on recovery, helping people regain confidence and reduce reliance on long-term care. Team members expressed pride in their contribution to preventing hospital readmissions and promoting people's independence. This meant that the service had a strong value base and clear goals.

However, following the merging of the hospital discharge team with the reablement service, there were emerging gaps in training that impacted staff confidence in delivering some aspects of care. Several carers noted a lack of confidence in managing complex tasks such as stoma care, or providing palliative care. While training sessions have taken place, some carers expressed a need for further support. This meant that a more proactive approach to skills development is needed to build skills and confidence across the team.

There was also concern among carers that the focus on reablement has been diluted as they are increasingly being asked to carry out more traditional home care tasks, such as meal preparation or support with personal care. Some staff felt unsupported and unsure of their role. Greater consistency in communication and shared understanding of goals is needed to maintain a reablement-focused approach.

Time constraints on visits impacted service delivery. Carers reported unrealistic expectations around visit durations. One carer shared an example of a ten-minute visit expected to include multiple rehabilitation tasks. Geographical challenges also impacted care delivery. Carers described difficulties navigating rural areas due to poor GPS signal, with some arriving late or struggling to locate addresses. This meant that poor scheduling and high caseloads affected the efficiency of the service and people's experience of care.

(Please see area for improvement in section 'How good is our leadership?')

These issues were also impacted by a lack of regular team meetings. Making protected time for regular team meetings would support improved communication and cohesion, allowing all staff to better understand expectations and align practice among carers. An area for improvement has been made to support this, with a view to promoting more collaborative working and restoring clarity of purpose across the team.

(Please see area for improvement 1)

Areas for improvement

1.

The service should establish regular team meetings to align roles and responsibilities and improve communication between hospital discharge and reablement carers.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state:

'My care and support is consistent and stable because people work well together.' (HSCS 3.19)

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate, as strengths in supporting people's recovery and independence through care planning just outweighed weaknesses.

Carers demonstrated genuine commitment to supporting people's recovery and independence. However, care and support plans were not consistently completed or detailed enough to guide safe and effective practice. In several cases, plans lacked up-to-date information about people's health needs, preferences, or risks. This meant that carers' ability to tailor support and respond to changes was compromised.

(Please see requirement 1)

Some people were receiving support without a formal care plan in place, with carers relying instead on brief diary entries, outlining basic tasks. For example, one person had a scheduled weekly shower, but this was missed in the first week due to lack of clarity in her plan. The person's care plan also indicated that cream should be applied three times daily, yet carers typically visited only once a day. This raised concerns about continuity of care and its impact on people's heath and wellbeing.

Where care plans did exist, they were not always updated in response to incidents or changes. For example, following a fall, a note was added to one person's one-page plan advising carers to reposition her shower chair, but there was no clear record of whether a wider risk assessment had been completed. Similarly, delays in a person's scheduled pain relief did not appear to trigger any formal review of her care arrangements.

Hospital discharge coordination also lacked consistency, as there had been a delay in some anticipated support being provided. Better pre-discharge planning and immediate follow-up support would improve people's experience of returning home and reduce risk. There were also concerns about premature discharge from the reablement service. During inspection we noted that there was not always evidence of reviews taking place when people's support was reduced, or when they were discharged from the service. This meant that their was an increased risk to people's health and safety.

Overall, while staff were responsive and dedicated, the lack of comprehensive and regularly updated care planning restricted their ability to provide fully personalised, safe, and outcomes-focused support.

A requirement has been made to ensure care and support plans are in place for all individuals, and that they contain sufficient detail to guide care safely and effectively. Improvements in this area will better support continuity of care and promote people's independence, comfort, and safety.

Requirements

1.

By the 10 October 2025, the provider must ensure that care plans are in place and contain sufficient detail to allow staff to provide effective support for people's health, welfare and safety needs.

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

a) Ensure people's choices and wishes on how to be supported are set out.

b) Ensure care plans are informed through effective risk assessments.

c) People and staff should have access to this information.

d) Review care plans when a significant change occurs, or if requested to do so.

This is to comply with Regulations 5 (1) and (5) (2)(b) (i) and (ii) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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