Abbeycare (UK)
Care Home Service

Erskine Mains
Meadows Drive
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PA8 7ED

Telephone: 01417 373 200

Type of inspection:
Unannounced

Completed on:
1 July 2026

Service provided by:
Abbeycare (UK) Limited

Service provider number:
SP2016012724

Service no:
CS2016347332

About the service

Abbeycare (UK) is a care home for adults experiencing alcohol and/or substance misuse difficulties. It is situated in Erskine close to local transport links, shops and community services. The service provides medical and residential treatment for up to 34 people.

Abbeycare (UK) is a purpose-built care home with two floors. There is a large dining area and various lounges throughout the home. People have unrestricted access to a small kitchen area and vending machines with drinks and snacks.

Bedrooms are single occupancy with ensuite shower facilities. There is unrestricted access to a large outside space to the rear and side of the building.

About the inspection

This was an unannounced follow up inspection to look at the service progress in meeting complaint requirements. The visit which took place on 25 June 2026 and started at 09:30. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service, we spoke with staff and management and reviewed documents.

Key messages

The service had made good progress in reviewing the policy and procedure on observations and had implemented improved systems for monitoring people in stage one detox.

Work to recruit permanent health care assistants for night shift was ongoing with bank staff used to supplement staffing in the interim.

The policy and procedure for missing people needed further clarification to ensure it set out the roles and responsibilities of key staff.

People being admitted to the service should be informed of the escalation procedure when people go missing.

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 good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate

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

How good is our leadership? 3 - Adequate

We noted progress had been made in revising the missing persons policy and procedure, and this offered more detailed guidance for staff. However, we found that it did not clearly define the responsibilities of key staff, and further work was needed to ensure roles and accountability were clearly understood and complied with. This has therefore been restated as an area for improvement.

Admission records did not demonstrate that people had been informed of the actions the service would take in the event that they were reported missing. While some progress had been made in changing electronic systems to enable this information to be recorded, this was not fully implemented at the time of the inspection. This has therefore been restated as an area for improvement.

Areas for improvement

1. The manager should ensure that the policy and procedure on missing people clearly defines the roles and responsibilities of key staff when responding to such incidents.

2. The manager should ensure that admission records clearly and consistently evidence that people have been informed of the service responsibility to act without delay in referring missing people to partner agencies.

How good is our staff team? 3 - Adequate

A new safe staffing assessment tool had been implemented to support daily staffing decisions, while taking into consideration the service occupancy and client risk factors. Pending the appointment of permanent night shift health care assistants, staffing levels were being flexed with support from bank staff. It was important that the reported efforts to recruit experienced and skilled nightshift health care assistants continues without delay. To ensure this is completed there will be an Area for Improvement.

Areas for improvement

1. The manager should ensure that night shift staffing levels are consistently maintained to support the safe and effective delivery of care for people, pending the recruitment and appointment of permanent health care assistants.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 24 June 2026, the provider must ensure systems are in place to enable accountable monitoring of people using the service. To achieve this, the provider must, at a minimum:

a) review and update the policy and procedure on detoxification observations to ensure it provides clear guidance on the required frequency of observations, based on people's circumstances and stage of detoxification;

b) ensure all staff receive training on the service policy and procedure for observing people, to support consistent understanding and application in practice;

c) clearly document the planned frequency of observations for each person, ensuring this is readily accessible and followed by relevant staff;

d) ensure all staff complete observations timeously and accurately, in line with the policy and procedure on observations, and in accordance with their professional responsibility for accurate record keeping (NMC/ SSSC guidance).

This requirement was made on 19 May 2026.

Action taken on previous requirement

The service policy and procedure on detoxification observations had been reviewed and circulated to appropriate staff. It offered improved information relating to observation frequency for people, while setting out the responsibilities of key staff when considering any change to this. Staff training records showed that the staff had been given guidance on the revised policy and procedure and they had signed to confirm that they had read and understood this.

We confirmed that the proposed frequency of observations was established at the initial clinical assessment of people entering the detox phase of the service. Care records showed that staff were recording observations in real time, which offered more accurate monitoring of people. An alert system had been put in place to remind staff and notify management where any observations had been delayed/missed and daily audits had been implemented. Together, the actions taken meant that there was improved oversight of the observations of people and we were satisfied that the service had made sufficient progress to meet the requirement.

Met - within timescales

Requirement 2

By 24 June 2026, the provider must evidence that staffing levels are consistently sufficient to ensure the safety and wellbeing of people using the service at all times. To achieve this, the provider must, as a minimum:

a) implement an increase in overnight staffing levels, to ensure adequate supervision of people, while ensuring management of risk during overnight hours;

b) review overnight staff deployment and allocation of responsibilities, to ensure that required housekeeping tasks do not detract from staff availability to support and monitor people safely;

c) review the arrangements for the nurse's treatment room to ensure they can safely maintain a clear line of sight along the corridor, which will support effective overnight monitoring and observation of people.

This requirement was made on 19 May 2026.

Action taken on previous requirement

The service has been seeking to recruit permanent health care assistants for nightshift for a number of months now, but for a variety of reasons no appointments have been made. Attempts to recruit were continuing, with recent interviews completed and further adverts placed across various recruitment sites and social media platforms. An application for Certificates of Sponsorship had been recently refused and follow up on this was needed to support applications from suitably qualified and skilled overseas candidates. The manager acknowledged that a more flexible recruitment process was needed to encourage more applicants.

To support staff allocation, the manager introduced a safe staffing assessment tool. This tool provides an overview of occupancy, client risk, and operational demands across departments, enabling proactive staffing decisions based on changing needs, risks and dependency level. From discussion with the manager and feedback from staff, we found that staffing was being flexed appropriately, and as indicated by the staffing assessment. Pending the appointment of permanent health care assistants, cover is being provided by bank staff.

Night shift task allocation lists have been introduced to provide clarity around staff roles and responsibilities. The aim is to ensure that nurses focus solely on clinical and observation duties, while responsibility for domestic tasks sits with recovery practitioners and, once in post, the health care assistants.

Our observation of the detox unit confirmed that the door to the nurses treatment room had been replaced with one fitted with a window, providing a clear line of sight down the corridor where people are accommodated. The manager also confirmed that progress had been made in installing a secure entry system at the entrance to the detox unit, with completion expected within the next few weeks. This will ensure that all entry and exit from the unit is controlled by the nurse.

Overall, we were satisfied that progress had been made and the requirement had been met. However, as work continues to secure the permanent increase in staffing through the appointment of night shift health

care assistants, we have restated this element of the requirement as an area for improvement.

Met - within timescales

Requirement 3

By 24 June 2026, the provider must evidence that robust systems are in place to support a clear and effective escalation procedure when people go missing. To do this, the provider must at a minimum:

a) review and update policy and procedural guidance on missing people to ensure staff roles, responsibilities and decision-making authorities are clearly defined for key staff in the escalation and response process;

b) provide training and guidance to all staff to ensure consistent understanding and application of the revised policy and procedures for missing people;

c) ensure a clear record of discussion with people is documented during the admission process, which sets out the service responsibility, and actions that will be taken in the event that people leave unannounced.

This requirement was made on 19 May 2026.

Action taken on previous requirement

The missing persons policy and procedure had been updated to provide more detailed guidance. However, we found that it did not clearly define the responsibilities of key staff, and further work was required to ensure roles and accountability were understood and complied with. Staff had been issued with a copy of the revised policy and procedure and records showed that they had signed to confirm their understanding of the content.

Admission records did not demonstrate that clients had been informed of the actions the service would take in the event that they were reported missing from the service. We discussed this with the manager and IT department at Abbeycare UK, who confirmed that system changes were being introduced to support recording this information. Although not fully implemented before our visit, action was taken during the inspection to activate this function so that staff could record this for all new admissions. Progress with this will be monitored through ongoing inspection activity.

Overall, while progress had been made in meeting this requirement, additional work was needed to ensure the policy on missing people clearly defined the roles and responsibilities of key staff. Furthermore, the service must ensure admission records clearly and consistently evidence that clients have been informed of the service responsibility to refer missing people to partner agencies. We have therefore restated these elements of the requirement as areas for improvement.

Met - within timescales

Requirement 4

By 24 June 2026, the provider must put systems in place to demonstrate compliance with the Duty of Candour Regulations (2018). To achieve this, the provider must, as a minimum, ensure:

a) all staff and management understand and follow the service Duty of Candour policy and procedures;

b) detailed and fully documented internal investigations are undertaken by Abbeycare (UK) to identify the circumstances of incidents which must be managed under Duty of Candour procedures. There must be a review of the factors contributing to this and any actions required to prevent reoccurrence;

c) contact is made with people, or their representatives, in line with the service policy and procedure on Duty of Candour. A sincere apology must be made in writing, along with a transparent written record of the investigation findings and an account of what occurred.

This requirement was made on 19 May 2026.

Action taken on previous requirement

We confirmed through discussion with the manager, staff and our review of staff training records, that staff had received, and were up to date with training on duty of candour. We sampled complaint records which confirmed that duty of candour had been appropriately implemented in two cases since our original complaint investigation visit. In both, records evidenced that procedures had been followed, appropriate records maintained and notifications had been made. We were therefore satisfied that this requirement had been met.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To ensure people's health and wellbeing needs are fully considered at the pre-admission stage, the provider should ensure that a comprehensive assessment is completed which provides a clear record of any identified risks and recommendations.

This is to ensure care and support is consistent with Health and Social Care Standard 4.14: My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.

This area for improvement was made on 19 May 2026.

Action taken since then

This area for improvement was not assessed during this inspection.

Previous area for improvement 2

To ensure clear and effective communication systems are in place, the provider should implement definitive guidance to all staff on what information about people can be shared and with whom.

This is to ensure care and support is consistent with Health and Social Care Standard 4.27: I experience high quality care and support because people have the necessary information and resources.

This area for improvement was made on 19 May 2026.

Action taken since then
This area for improvement was not assessed during this inspection.

Previous area for improvement 3

An accurate and up to date record of all incoming and outgoing communications relating to people's care and support should be maintained to ensure accountability, continuity and timely response.

This is to ensure care and support is consistent with Health and Social Care Standard 3.19: My care and support is consistent and stable because people work together well.

This area for improvement was made on 19 May 2026.

Action taken since then
This area for improvement was not assessed during this inspection.

Complaints

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

Detailed evaluations

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

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