Priory Supported Living in Scotland
Housing Support Service

Millburn
3 Glencairn Gardens
Halfway, Cambuslang
Glasgow
G72 7QE

Telephone: 01416 410 407

Type of inspection:
Unannounced

Completed on:
20 June 2025

Service provided by:
Craegmoor Supporting You Limited

Service provider number:
SP2011011425

Service no:
CS2011281086

About the service

Priory Supported Living in Scotland is registered as a housing support and care at home service, supporting adults with learning disabilities to live in their own homes. The provider is Craegmoor Supporting You Limited.

Support provision varied from a few hours per week up to 24-hours a day for some people. Staff members provided both personal care and housing support to individuals. Examples of this included medication support, personal care, shopping, and socialising.

The registered manager co-ordinates the overall running of the service, and is supported by the senior support worker who locally manages the staff team who provide direct support to people.

At the time of the inspection, the service was provided to 12 people living in the Cambuslang, East Kilbride and Rutherglen areas.

We visited and spoke with people who lived across the three geographical areas covered by the service.

About the inspection

This was an unannounced inspection which took place on 17, 18, 19 and 20 June 2025 between 09:30 and 17:30. 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, registration information, information submitted by the service, and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with six people using the service and four relatives
- spoke with nine staff and management
- visited people in their homes and observed practice
- reviewed documents.

Key messages

- The provider must ensure that staff are supporting medication in line with policy and best practice.
- Management oversight of key areas must improve to ensure people are kept safe and their needs are met.
- An effective quality assurance system must be implemented in order to achieve management oversight in the service and drive improvement.
- We observed warm and caring staff interactions and supportive relationships with people experiencing care.
- The provider must ensure improvements to personal plans and assessments of people's needs in order to improve outcomes for people experiencing care.
- Personal plans must be regularly reviewed with input from people experiencing care and their relatives/representatives.
- The provider must make improvements to incident recording and investigations, including communication with other relevant bodies to promote a culture of continuous improvement.
- In order to promote good standards of care delivery, the provider must ensure that people are supported by staff who have sufficient skills and knowledge for the work they perform.
- At the last inspection, three areas for improvement were made and none were met.
- As a result of our findings, we have made six requirements and two areas for improvement.

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?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak
How well is our care and support planned?	2 - Weak

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

How well do we support people's wellbeing? 2 - Weak

We found the performance of the service in relation to this quality indicator weak. This applies to performance in which strengths can be identified, but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect people's experiences and outcomes.

People valued the care provided and felt staff treated them with compassion and respect. These positive interactions helped to promote dignity in day-to-day support.

However, key areas of care and support were poorly managed. Medication was not supported in line with organisational policy or best practice. People's medication needs were not clearly identified or documented. It was unclear whether they required prompting from staff or full support with administration of medicines. Written records that were required to evidence medication support provided by staff were missing or incomplete. This raised serious concerns about safety and accountability, placing people at risk of harm. The service must revise their medication practices and ensure they are aligned with best practice and organisational policies. **(See Requirement 1)**

Personal plans lacked essential detail and often failed to reflect people's current needs, preferences, or health conditions. Some of the language used was deficit-focused and stigmatising, which risked undermining people's dignity. Although records included entries suggesting that reviews had taken place, there was no supporting evidence to show that these were meaningful or carried out in line with statutory requirements. There was no indication that people or their families had been involved in the review process, and personal plans had not been updated to reflect changes in needs. Goals, risks, and support strategies remained outdated or unclear. As a result, care planning and risk assessment were not person-centred or responsive to people's current circumstances.

Health needs were not consistently identified, planned for, or monitored. Staff did not have access to the required information to effectively meet people's needs and keep them safe. Significant gaps were found in the management of conditions such as epilepsy, with no care planning for emergency medication. Staff did not present with the necessary skills or knowledge to safely support needs related to epilepsy. Other health needs were not monitored or addressed well. This included nutrition, hydration, and the risk of falls. When people needed input from health professionals, referrals were sometimes missed or not recorded. This put people at greater risk of harm, delayed treatment, and their health needs not being met. **(See Requirement 2)**

Support arrangements, including the scheduling of visits, were not always aligned with people's needs or preferences. Concerns were raised about early evening visits, which sometimes left people without support for extended periods. While some individuals accessed the community, this was not consistently planned or recorded. As a result, there was a risk that people were not being supported in a way that promoted meaningful outcomes or enabled them to achieve their personal goals.

Legal frameworks designed to protect people who cannot make decisions for themselves were not being followed. There was no recorded evidence to show that the necessary legal authorisations were in place to support treatment or interventions for people who lacked capacity. Staff were unable to locate relevant documentation or explain its significance. This raised serious safeguarding concerns and meant that individuals were at risk of receiving care or treatment without the appropriate legal authority.

These findings highlighted a lack of effective oversight and poor coordination across key areas of care. Weaknesses were identified in personal planning, medication management, staff knowledge, and legal compliance. As a result, people were placed at unnecessary risk, and their rights and wellbeing were not fully protected. Processes to support safe and person-centred care had not been clearly defined or reliably followed, and accountability was lacking. Improvements must be made to ensure that people's health and wellbeing needs are consistently identified, planned for, and met in line with legal duties and best practice.

Requirements

1. By 29 September 2025, the provider must ensure that people's medication needs are safely met to protect their health and wellbeing and ensure positive outcomes. To achieve this, the provider must revise and implement safe, effective medication procedures that are in line with current best practice and organisational policy.

This must include, but is not limited to:

a) clearly assessing and documenting each person's medication support needs, including whether they require support with administration or prompting;

b) ensuring medication administration records (MAR) are accurate, complete, and reflect current prescriptions;

c) implementing regular audits of medication systems and staff practice to identify and respond to errors or gaps; and

d) providing staff with appropriate training and competency assessments in medication management.

This is to comply with Regulation 4(1)(a) and 15(b)(i) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

'I experience high quality care and support that is right for me' (HSCS 1.19)

and

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

2. By 29 September 2025, the provider must ensure that people's health needs are clearly identified, planned for, and monitored to support their safety, wellbeing, and positive outcomes. To achieve this, the provider must implement systems that ensure health needs are recognised and met consistently across the service.

This must include, but is not limited to:

a) ensuring all health conditions, including epilepsy, are accurately assessed and documented in personal plans, with clear guidance for staff on how to respond, including the use of emergency medication where applicable;

b) ensuring staff have access to up-to-date risk assessments and relevant information to support people safely;

c) ensuring staff have the necessary training, skills, and confidence to support people with identified health needs;

d) putting in place systems to monitor key health areas, such as nutrition and hydration; and

e) recording and acting on referrals to health professionals, ensuring timely access to appropriate external support.

This is to comply with Regulation 4(1)(a) and 5(1) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

'I am assessed by a qualified person, who involves other people and professionals as required' (HSCS 1.13)

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 leadership? 2 - Weak

We found the performance of the service in relation to this quality indicator weak. This applies to performance in which strengths can be identified, but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect people's experiences and outcomes.

Management oversight was found to be ineffective, and this had a direct impact on the safety, rights, and wellbeing of people using the service. Although organisational policies and systems for quality assurance were in place, they had not been consistently followed or monitored.

Audits were carried out infrequently and often lacked sufficient detail. Key areas such as medication administration, staff registration, Protecting Vulnerable Groups (PVG) compliance, visit timings, and financial records had not been regularly checked or documented. As a result, risks had not been identified, issues had not been addressed, and accountability could not be demonstrated.

Staff practice and competency had not been formally observed, and there was no recorded evidence to show that these checks had taken place. The training information related to staff needs was out of date and inaccurate, which raised further concerns about how well staff training and supervision had been managed. These gaps highlighted a lack of effective oversight in ensuring staff were properly supported, monitored, and held to appropriate standards.

Where quality assurance activities did occur, they were inconsistently applied. We identified significant incidents, including those involving medical treatment, had not been reported to the Care Inspectorate as required. Follow-up actions and learning from incidents were poorly documented, and personal plans were not updated to reflect changes after events such as distress episodes or falls. This limited the service's ability to reduce risk for people experiencing care. **(See Requirement 1)**

Financial governance was inadequate. Staff showed uncertainty about their roles in supporting and safeguarding people's finances. Financial care plans were missing, and management did not provide evidence of regular audits or oversight. In one instance, an individual with an appointeeship arrangement lacked a financial care plan, and staff could not explain how finances were recorded or reviewed. This exposed people to potential financial harm or exploitation.

Although a service improvement plan was in place, this did not show evidence of involvement from people experiencing care and their relatives/representatives. Team meetings and staff supervision were not consistently conducted in line with organisational policies. Opportunities for staff and people experiencing care to contribute to improvement were limited or undocumented. Improving opportunities for involvement will reassure people they are being listened to and have confidence in the service being provided.

Previous areas for improvement in relation to quality assurance had not been addressed, raising concerns about the service's ability to manage risks and implement timely changes. This slow pace of change has potential to put people at risk and negatively impact on outcomes for people.

Weak leadership in quality assurance and improvement was evident. Key aspects of practice lacked sufficient oversight, leaving risks unidentified and unmanaged. Improvements were needed to establish effective, accountable systems that proactively support the delivery of safe, high-quality care and support. **(See Requirement 1)**

Our overall findings, as reflected throughout this inspection report, highlight that the culture of the service needs to be addressed to ensure that this influences better experiences for people. When possible, the provider should consider the involvement of advocacy services, or another external body that support change in this area which will be key to required improvements.

Requirements

1. By 29 September 2025, the provider must implement effective management oversight and quality assurance systems to ensure that care and support are safe, consistent, and aligned with best practice. This is essential to improve outcomes for people and reduce risks associated with poor monitoring and lack of accountability.

This must include, but is not limited to:

a) establishing and maintaining a regular programme of audits that covers critical areas such as personal planning, medication management, staff training and registration, PVG compliance, and financial procedures;

b) ensuring that audit findings are recorded, analysed, and used to identify risks and drive measurable improvements;

c) putting in place clear systems for monitoring staff competency, including formal observations and supervision;

d) maintaining accurate and up-to-date records that support transparency and accountability in service delivery; and

e) ensuring that managers have the capacity, training, and support required to carry out effective oversight and quality assurance.

This is to comply with Regulation 4(1)(a) and 7(2)(c) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

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

and

'I use a service and organisation that are well led and managed' (HSCS 4.23).

How good is our staff team? 2 - Weak

We found the performance of the service in relation to this quality indicator was weak. This applies to performance in which strengths can be identified, but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect people's experiences and outcomes.

We were not assured that staff had received appropriate induction and training to equip them with the skills and knowledge needed to provide safe, effective support. Whilst staff were described as kind and caring, with relatives recognising their warmth and commitment, there were serious concerns about how well they had been prepared for their roles. This lack of preparation placed people at risk of receiving care that did not fully meet their needs or support their wellbeing.

Staff spoke positively about their relationships with colleagues and the support from management, however, evidence showed that induction processes were inconsistent and insufficient. Shadowing and formal induction for new staff were not reliably provided, including for those working with individuals with complex needs. The lack of a structured induction process led to gaps in essential knowledge and skills. As a result, this has potential to put people at risk of harm. **(See Requirement 1)**

Recruitment and internal promotions were also found to be poorly managed. There were failings in the application of safer recruitment practices, particularly where staff were promoted within the service. Key documentation, including references, PVG updates, and records of completed induction, were often absent. Training records were incomplete, especially in critical areas such as medication management, epilepsy, and emergency interventions. These failings raised significant concerns around staff competency, and the overall safety and effectiveness of the support being provided. **(See Requirement 2)**

Support was not always person-centred. Visits were sometimes scheduled at times that conflicted with people's preferences or routines, such as early evening meals, that left long gaps without support. One relative reported, their family member frequently returned to bed after early visits due to the absence of later support, which negatively affected their quality of life. There were also instances where personal care did not respect individual preferences, such as a person requiring female carers receiving male staff instead, impacting upon their dignity.

Whilst individual staff demonstrated compassion and commitment, the service lacked the necessary staffing structures, oversight, and coordination to ensure safe and effective care. Significant improvements were required to strengthen staffing arrangements and support better outcomes for people.

Requirements

1.
By 29 September 2025, the provider must ensure that all staff, including those internally promoted, are appropriately and safely recruited in line with best practice guidance, 'Safer Recruitment Through Better Recruitment (Scottish Government, 2016).' This is to ensure that only suitable and appropriately vetted individuals are employed to support people's care and wellbeing.

This is to comply with Regulation 4(1)(a) and 9(2)(b) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

'I am confident that people who support and care for me have been appropriately and safely recruited' (HSCS 4.24).

2.
By 29 September 2025, the provider must ensure that all staff receive a structured induction and appropriate training to enable them to carry out their roles competently and confidently. This is essential to ensure people experience safe, high-quality care from staff who are fully prepared and supported in their work.

This must include, but is not limited to:

a) providing a structured and role-appropriate induction for all new staff, including shadowing opportunities and tailored support for those working with people who have complex needs;

b) ensuring training is completed and recorded in key areas such as medication management, epilepsy awareness, and management;

c) maintaining an accurate and up-to-date training matrix to support effective oversight and workforce planning; and

d) assessing and recording staff competency as part of the induction process and through regular supervision.

This is in order to comply with Section 8 of the Health and Care (Staffing) (Scotland) Act 2019.

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

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes. (HSCS 3.14).

How well is our care and support planned? 2 - Weak

We found the performance of the service in relation to this quality indicator was weak. This applies to performance in which strengths can be identified, but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect people's experiences and outcomes.

Carers, friends and family members were often involved informally in people's lives, and key staff demonstrated commitment to maintaining contact. However, this involvement was not consistently structured, evidenced, or embedded in the personal planning process. It is important that services demonstrate that people are included in personal planning, and are put at the centre of decision making about their care. (See 'Guide for Providers on Personal Planning: Adults', Care Inspectorate, 2021). **(See Area for Improvement 1)**

Key workers maintained contact with family members and, in some cases, with legal representatives such as welfare guardians, however, this was not consistent. Some guardians reported that they had not been kept informed or involved, which was also reflected in feedback from social work. While several relatives said they felt informed and supported, and described staff as respectful and approachable, this was not the experience of all. Inconsistent communication limited the service's ability to fully involve families and representatives in decisions about care.

However, whilst those strong relationships were valued by families, they were not reflected in the service's documentation. Records of family involvement were inconsistent or missing altogether. Reviews of support plans did not evidence the participation of families or legal representatives, and several guardians reported they had not been invited to contribute, despite having key decision-making roles. This meant that people were at risk of not receiving person-centred care that aligned to their preferences and rights. **(See Requirement 1)**

Whilst personal relationships with families existed, these had not been formally embedded in the care planning or review processes. Improvements were needed in how involvement was documented, how feedback was used to inform care, and how relatives were supported to be active partners in planning and decision-making. **(See Area for Improvement 2)**

Requirements

1. By 29 September 2025, the provider must ensure that people experience care and support that is person-centred and reflects their rights, preferences, and legal protections. This is essential to ensure that people are actively involved in decisions that affect them, and that care is delivered in a way that respects their views and legal status.

This must include, but is not limited to:

a) ensuring that families, legal representatives, and guardians are meaningfully involved in care planning and reviews, in line with the person's wishes and any legal arrangements;

b) keeping accurate and up-to-date records of who has been involved in reviews and decision-making;

c) making sure staff understand their responsibilities in involving families and representatives, and have access to appropriate guidance or training where required; and

d) reviewing and improving systems for documenting family and representative involvement to ensure decisions are transparent and inclusive.

This is to comply with Regulation 5(2)(c) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

'I am fully involved in developing and reviewing my personal plan, which is always available to me' (HSCS 1.15)

and

'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, or guardian, are sought and taken into account' (HSCS 2.12).

Areas for improvement

1. The provider should deliver support to people based on their needs and the outcomes they wish to achieve. These outcomes should be recorded within people's personal plans and evaluated.

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

'I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential' (HSCS 1.6)

and

'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors' (HSCS 1.25).

2. To ensure people experience care and support that is right for them, personal plans should remain accurate and up-to-date. Reviews should be undertaken as and when there is a change in people's circumstances, and within six months.

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

'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).

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 promote people's health and wellbeing, the provider should ensure that people's care and support needs are reviewed on a six-monthly basis or, as and when required to ensure needs are fully met. This should include involvement from the person supported, significant people in their lives, and professionals. Robust quality assurance measures should be put in place to ensure that the service has an accurate overview of reviews.

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

'My personal 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).

This area for improvement was made on 18 April 2024.

Action taken since then

This area for improvement has not been met and has been reworded under Key Question 5: 5.1 - Assessment and personal planning reflects people's outcomes and wishes, and 5.2 - Carers, friends and family members are encouraged to be involved.

Previous area for improvement 2

To support quality assurance, the service should ensure that any audits carried out provide clear details of actions taken to address areas for improvement identified. This should include, but not limited to, information gathered from care reviews and people's satisfaction meetings and surveys to inform the overall service improvement plan.

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

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

This area for improvement was made on 18 April 2024.

Action taken since then

This area for improvement has not been met and has now been included in Requirement 1 under Key Question 2: 2.2 - Quality assurance and improvement is led well.

Previous area for improvement 3

The service should improve the consistency of recording within personal plans to ensure people receive the right support at the right time.

To do this, the service should, at a minimum:

a) ensure people receiving care has a detailed personal plan reflecting a person-centred and outcome focused approach, which is evaluated regularly; and

b) ensure they contain accurate and up-to-date information which directs staff on how to meet people's care and support needs.

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

'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).

This area for improvement was made on 18 April 2024.

Action taken since then

This area for improvement has not been met and has been reworded under Key Question 5: 5.1 - Assessment and care planning reflect people's needs and wishes. (See Area for Improvement 1).

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?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.1 Staff have been recruited well	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How well is our care and support planned?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak
5.2 Carers, friends and family members are encouraged to be involved	2 - Weak

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