Stobhill Nursing Home
Care Home Service

70 Stobhill Road
Glasgow
G21 3TX

Telephone: 01414137050

Type of inspection:
Unannounced

Completed on:
28 January 2026

Service provided by:
Clyde Care Limited

Service provider number:
SP2016012834

Service no:
CS2022000211

About the service

Stobhill Nursing Home is registered to provide a care service to a maximum of 60 older people over the age of 65 years, with one place being used by a named individual under the age of 65.

The home is a purpose-built two storey building in the residential area of Springburn in Glasgow. It is situated next door to Stobhill Hospital and is close to local shops and community amenities. The building provides single occupancy accommodation over two floors, all with partial ensuite facilities.

There are public lounges and dining rooms as well as shared toilets and specialised bathing or showering facilities. People have access to a private, secured garden area accessible from the ground floor dining room.

There were 43 people using the service at the time of inspection.

About the inspection

This was an unannounced follow up which took place on 27 and 28 January 2026 between the hours of 07.45 and 15:45. The inspection was carried out by three 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 three people using the service and three of their family/friends
- spoke with 11 staff and management
- observed practice and daily life
- reviewed documents.

Key messages

- People were supported by a kind and compassionate staff who knew them well
- Improvement was seen in supporting people's nutrition and hydration needs
- Quality assurance processes to support continuous improvement needed further improvement
- Medication management had improved
- People's personal plans had improved to ensure care delivery reflected people's needs, risks and preferences.

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 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 followed up on three requirements that related to this quality indicator. See section "What the service has done to meet any requirements we made at or since the last inspection".

We were satisfied that sufficient progress had been made to meet the requirements, however we have identified an area for improvement to ensure that when bedroom doors are locked, the service has in place an approach that best supports people's rights.

In recognition of improvements made we have revised the evaluation of this quality indicator from weak to adequate as where there are some strengths, these just outweigh weaknesses.

Areas for improvement

1. To protect the rights of people, the provider should ensure that when changes are made to people's care and support these are lawful, safe, transparent and inclusive.

Any changes are aligned to relevant legislation and good practice guidance, supported by clear and up-to-date risk assessments. Clear records should evidence the decision making process supported by meaningful involvement of appropriate agencies, stakeholders and families or legal representatives.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified" (HSCS 1.3).

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

We followed up on a requirement that related to this quality indicator. See section "What the service has done to meet any requirements we made at or since the last inspection".

We were satisfied that sufficient progress had been made to meet the requirement. In recognition of improvement made we have revised the evaluation of this quality indicator from weak to adequate as where there are some strengths, but these just outweigh weaknesses.

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

Requirements

Requirement 1

By 23 January 2026 to promote the safety, health and wellbeing of people the provider must ensure staff receive essential training for their role and responsibilities.

To do this the provider must at a minimum:

a) Ensure all staff receive IDDSI training and have their competency assessed.
b) Ensure improved presentation of modified meals.
c) Have robust auditing processes in place to ensure people are receiving the correct diet.
d) Ensure all records relating to nutrition and hydration are consistently and timeously completed and take swift corrective action where needed.
e) Ensure all records relating to personal care are accurate and take swift corrective action when needed.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11), and "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).

This requirement was made on 12 December 2025.

Action taken on previous requirement

Mealtime audits showed that people on modified diets were receiving the correctly prescribed diet, and staff demonstrated good awareness of who required modified diets. Dietary information folders were available in each dining room for staff to refer to. Meal choices were offered to everyone, including those on modified diets. Food was nicely presented and looked appetising, which encouraged people to eat well.

Staff had completed updated International Dysphagia Diet Standardisation Initiative (IDDSI) training, and competency assessments were ongoing. Food and fluid charts had improved, with clear intake targets set for each individual, and these were being consistently met. This indicated that people's nutrition and hydration needs were being effectively monitored and supported. For those requiring weight management, food fortification to increase calorific intake was clearly recorded.

All food and fluid charts reviewed at intervals throughout the inspection were up-to- date, demonstrating real-time completion. Personal care records were accurately and consistently recorded. This demonstrated

good record-keeping practices and effective oversight of people's day-to-day care which gave assurance that people's health and wellbeing was supported.

Met - within timescales

Requirement 2

By 23 January 2026 to ensure people are kept safe and their wellbeing is promoted the provider must keep accurate records of the medication they have taken.
As a minimum the provider must:

a) Establish written procedures for identifying, documenting, and returning unused, expired, or discontinued medications to the pharmacy.
b) Through monitoring processes ensure staff competency in understanding and implementation of best practice guidance for returns medications.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me" (HSCS 1.19) and "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).

This requirement was made on 12 December 2025.

Action taken on previous requirement
The provider had in place a protocol for managing returns medication. This was available for staff reference and stored in the medication treatment room. The provider's medication management policy had recently been reviewed, and it provided robust guidance on the safe handling of returns medication. The returns records had been reviewed by inspectors, and entries showed that medication for return to the pharmacy was most often recorded at the time when items were placed in the locked box.

However, we noted that this recording practice was not consistent across the staff team. This issue had already been identified through an internal audit, and the management team were addressing it.

Medication competencies and pharmacy-led training had been completed. This ensured staff had the knowledge and skills required to manage medicines safely. Improvements meant that people could be confident that their medicines were being handled in line with good practice and organisational policy.

Met - within timescales

Requirement 3

By 23 January 2026 to promote people's rights and ensure positive outcomes for people in line with their choices and wishes, the provider must clearly demonstrate collaborative decision-making.

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

a) Have in place a locked door policy aligned to Mental Welfare Commission (2021) best practice guidance

"Rights, risks and limits to freedom".
b) Ensure robust risk assessments are in place in relation to people's rights to protection from potential restraint.
c) Evidence collaborative decision making with relevant stakeholders, or people's representatives when legal powers are in place.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice". (HSCS 4.11).

This requirement was made on 13 November 2025.

Action taken on previous requirement

The provider had a restraint policy in place, which encompassed locked-door information. Residents who had their doors locked had risk assessments in place that referenced relevant legislation. Families, including those with Guardianship or Power of Attorney, had been consulted, and decisions had been made in order to safeguard people's belongings.

However, the legislative principles involved had not been fully followed. This meant some residents' doors were being locked during the day at the request of family members, despite there being no identified risk to the individual. This constituted a form of restraint and required careful consideration to ensure it benefited the person rather than meeting family preference.

The management team had contacted families to discuss this and had arranged social work review meetings to determine how best to support people's rights. (See Area for Improvement 1 in the "How well do we support people's wellbeing" section of this report).

Met - within timescales

Requirement 4

By 23 January 2026 the provider must ensure people are safe, risk is reduced and people receive quality care and support that meets their needs. To do this, the provider must, at a minimum:

a) Ensure audits are consistently completed.
b) Ensure audit tools in use are robust to more fully identify improvement and reduce risk.
c) Ensure plans are in place to action and complete issues identified in the audit process.
d) Ensure strong management oversight of the quality assurance processes.

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.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance systems". (HSCS 4.19).

This requirement was made on 12 December 2025.

Action taken on previous requirement

Audits had been completed across the service, but this had been inconsistent. Overall, audits were being carried out, but many were inaccurate, incomplete, or not followed through. Misinterpretation of questions, incorrect scoring, and inconsistent action planning meant that audits were not reliably identifying risk or driving improvement.

Stronger management oversight had been required to ensure that quality assurance processes were effective.

This requirement has not been met and will be extended until 6 April 2026 and re-assessed at the next inspection.

Not met

Requirement 5

By 23 January 2026 the provider must ensure that information in personal plans is up-to-date and sets out the health, welfare and safety to meet people's needs.

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

a) Ensure personal plans are updated when a person's needs change and this is consistently evidenced throughout the plan.
b) Ensure all appropriate care plans are in place and reviewed regularly.
c) Ensure information which no longer reflects people's needs is removed and archived.
d) Ensure the auditing of personal plans is robust and objective.
e) Ensure personal plans six monthly reviews include focused future outcomes for people.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice". (HSCS 4.11).

This requirement was made on 12 December 2025.

Action taken on previous requirement

Personal plans that were viewed indicated that they were up-to-date and contained relevant, current information. This meant staff had clear and accurate guidance to support each person safely and consistently, and ensured that care delivery reflected individuals' present needs, preferences, and risks.

Personal plans and risk assessments were being reviewed at least monthly or whenever a change occurred. All out-of-date information had been archived. This ensured that staff were always working from accurate, current guidance and that the care provided reflected each person's most up-to-date wants and needs.

Six-monthly reviews were also up-to-date, and the service had a clear plan in place to ensure these continued to take place regularly. There was evidence of meaningful input from family members, next of kin, and those with Power of Attorney/Guardianship responsibilities. Records also showed that identified changes and required actions had been implemented.

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 have accessibility to facilities and to maintain people's dignity and respect the provider should ensure appropriate storage of equipment used to help people move or transfer.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me". (HSCS 1.19).

This area for improvement was made on 12 December 2025.

Action taken since then

All communal bathrooms and shower rooms had been checked, and no unnecessary equipment had been stored. One ground-floor bathroom had been out of use due to flooding and was being used temporarily for equipment storage until repairs could begin. Management had discussed contingency plans and later identified an alternative storage area downstairs.

However, staff working on the upper floor had confirmed there had been no designated storage space on the upper floor. Overall, equipment for use on the upper floor had been stored wherever space was available. This had been discussed with management, and a dedicated storage area had now been identified for the upper floor.

This area for improvement has been met.

Previous area for improvement 2

To maintain high standards of cleanliness and reduce the risk of cross-contamination, the service should ensure:

a) Adequate numbers of external waste bins are provided to meet the needs of the home.
b) External bins are maintained in a state of good repair.
c) The external bin area is checked at regular intervals throughout the day to ensure bins are not over-full, lids are closed and the surrounding area is kept clean and free of debris.
d) Records are maintained to provide evidence of these checks.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that: "I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment". (HSCS 5.22).

This area for improvement was made on 12 December 2025.

Action taken since then

The external bin area had been observed during the inspection. One general waste bin was over-full, but the rest of the area was clean, tidy, and well maintained. Collection of the general waste bins was due and had been completed that day. Although daily checks had been recorded inconsistently, this had already been identified and was being addressed by the management team to ensure consistent recording going forward.

This area for improvement has been met.

Previous area for improvement 3

To ensure better evidence that people continue to experience activities that are right for them and meet their needs the provider should:

a) Ensure staff accurately record the activities people engage in daily.
b) Ensure information is recorded in a way that details the level of people's engagement in activities and the outcome achieved.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My care and support meets my needs and is right for me". (HSCS 1.19).

This area for improvement was made on 17 October 2025.

Action taken since then

A sample of daily records had been viewed. These were clear and concise, and most contained details of the personal care provided by staff, as well as the daily activities people had engaged in and how outcomes had contributed to people's wellbeing. This demonstrated that staff were recording meaningful information that reflected people's day-to-day experiences.

Activity records had also been viewed, and discussions had taken place with activities staff. The records contained clear information about the activities people had taken part in. Through discussion with staff and from the evidence recorded in activity notes, it was evident that when a person was not participating in or enjoying a particular activity, an alternative option had been offered.

However, it was noted that the same information was being recorded in multiple places. During discussions with the management team, we were informed of their plans to introduce electronic recording to eliminate

this duplication. This meant staff would be able to record information more efficiently and have more time to engage with people.

This area for improvement has been met.

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 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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Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

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