Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net.

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This report was prepared and published by Healthcare Improvement Scotland.

www.healthcareimprovementscotland.org
1 Background

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 2 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (hereafter referred to as ‘the Act’)
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service.

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve. Please see Appendix 5 for more information about the National Care Standards.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure compliance against expected standards and regulations
- be firm, but fair
- have members of the public on some of our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the independent healthcare services we inspect
- if necessary, inspect services again after we have reported the findings
- publish reports on our inspection findings which will be available to the public in a range of formats on request, and
- listen to your concerns and use them to inform our inspections.

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service.
Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300
Email: hcis.chiefinspector@nhs.net
2 Summary of inspection

Graham Anderson House, Glasgow, is a specialist assessment and rehabilitation hospital for people with a non-progressive acquired brain injury. It forms part of the network of specialist rehabilitation centres provided by the Brain Injury Rehabilitation Trust with the registered provider as the Disabilities Trust.

The service states that: ‘The service specialises in the assessment and rehabilitation of people who are experiencing behavioural disorders following a brain injury. Individuals may also have severe cognitive, physical and/or emotional problems including verbal and physical aggression, impaired social functioning, disinhibited behaviours and neuropsychiatric symptoms.’ Their goal is to enable service users to function as independently as possible, develop their lives as they choose and participate in the wider community.

We carried out an unannounced inspection to Graham Anderson House on Wednesday 7 August and Monday 12 August 2013.

The inspection team was made up of two inspectors, with support from a project officer. One inspector led the team and was responsible for guiding them and making sure the team members agreed the findings reached. See Appendix 4 for membership of the inspection team visiting Graham Anderson House.

We assessed the service against three quality themes related to the National Care Standards. Based on the findings of this inspection, this service has been awarded the following grades (more information on grading can be found on page 22):

**Quality Theme 1 – Quality of care and support: 2 - Weak**
**Quality Theme 3 – Quality of staffing: 3 - Adequate**
**Quality Theme 4 – Quality of management and leadership: 3 - Adequate**

During the inspection, evidence was gathered from various sources. This included the relevant sections of policies, procedures, records and other documents including:

- hospital website
- patient care records
- policies on healthcare, adult protection, recruitment and complaints
- minutes from meetings
- risk assessments
- complaints policy, incident recording and management
- prescription sheets
- medication recording sheets
- controlled drug book
- medication policy
- medication audits
- training records, and
- training plans.
We had discussions with a variety of people employed at Graham Anderson House including:

- the manager
- senior nurses
- registered nurses
- rehabilitation support workers, and
- a consultant neuropsychologist.

During the inspection, we observed how staff cared for and worked with people who use the service. We took into account The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011.

Overall, we found evidence in the Graham Anderson House that:

- there are systems in place to support the management of medications, and
- staff felt involved in being able to make improvements within the service.

We found that improvements were needed in specific areas. This included:

- clearer documentation concerning the use of covert medication
- clearer documentation when people are subject to restraint, and
- ensuring the model of care being used is clearly communicated to all staff.

This inspection resulted in 10 requirements and four recommendations. The requirements are linked to compliance with the Act and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

The Disabilities Trust, the provider, must address the requirements and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Graham Anderson House for their assistance during the inspection.
3 Progress since last inspection

What the provider has done to meet the requirement we made at our last inspection on 11 October 2012

Requirement 1

The provider must maintain a log of any complaints raised about the service and make these available to Healthcare Improvement Scotland on request.

Action taken
The provider has now started a log of complaints. We saw the logo during the inspection. This requirement is met.

What the service has done to meet the recommendation we made at our last inspection on 11 October 2012

Recommendation a

Graham Anderson House should introduce a method of recording when and by whom actions have been completed when areas for improvement have been identified.

Action taken
We looked at the service’s action plans to address areas of improvement. We saw that these identified who was responsible for the actions, the timescale for completion and when they were completed. This recommendation is met.
4 Key findings

Quality Theme 1

Quality Statement 1.4

We are confident that within our service, all medication is managed during the service user’s journey to maximise the benefits and minimise any risk. Medicines management is supported by legislation relating to medicine (where appropriate Scottish legislation) and current best practice.

Grade awarded for this statement: 3 - Adequate

We saw that nursing staff check the stock levels of controlled drugs between each shift to ensure that they are correct. Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers.

There is a procedure in place for staff to follow should they make a medication error. Staff we spoke with during the inspection were able to describe the procedure they would follow. We also saw that when staff had made a medication error they:

- completed a review of the incident to identify any areas for learning
- had a meeting with a senior nurse to discuss, and
- completed a competency check to make sure they were following the correct procedures for giving out medication. A competency check is when another nurse observes a nurse giving out medication to make sure they are doing it properly.

We also saw that staff undergo competency checks from time to time. This helps to make sure that they continue to give out medications in a safe manner and follow the correct procedures.

During the inspection, we looked at 23 medicine prescription sheets. We found that they were all completed correctly. The prescriptions included the person’s name, date of birth and allergies. All prescriptions were legible and had been signed and dated by the prescribing doctor. The prescriptions also identified the dose, frequency and the method by which the medicine should be administered, for example by mouth or injection. All but one of the prescription sheets had a picture on the front to help identify the person being given the medication. The one who did not have a picture had been identified as needing one during a recent medication audit. This was yet to be completed.

We also looked at nine prescription recording sheets during the inspection and saw that these were all completed correctly.

We saw that nursing staff check the prescription recording sheets between each shift to make sure that these have been completed correctly. If there are any discrepancies, these are investigated to find out the reason.

Some of the people who use the service are able to manage their own medicines. We saw that people who do have had a risk assessment. There are agreements in place signed by the manager, nursing staff and the person using the service which sets out how they should manage their medicines.

We saw that audits of medication practices are carried out in the service.
There is a rapid tranquilisation policy which describes what process should be followed if staff have to give people medication to sedate them in an emergency situation. The policy outlines the need for continued physical monitoring of the person for a period after the medication has been given. We were unable to see if this policy had been followed during the inspection as the service has not had to sedate any patients recently.

Areas for improvement

We saw that some people within the service use medication that is delivered in single doses. This medication has an ingest date on the label. This is the date that the pharmacy is directing that the medication should be given on. During the inspection, we saw that staff were not always administering the medicine on the date they were supposed to. A requirement is made (see requirement 1).

The service has a process in place to destroy any controlled drugs. Part of the process is that staff should crush the tablets before they are disposed of. We saw examples of controlled drugs which had been disposed of without being crushed (see recommendation a).

When nurses administer medication they should be able to check the expiry date on the medication strip. We saw examples where the strip had been cut and the expiry date was no longer visible (see recommendation b).

We looked at an example of when a person was being given medication covertly. This means that staff have decided that the medication is necessary for the person and disguise it in food or a drink to make sure the person takes it. We had some concerns with the process the service was following.

- There was no documented evidence that the person’s representative had been consulted about the decision to give the medication covertly.
- The service had not taken advice from a pharmacist about the ways the medication should be given before they started to give it. This advice had been sought by the time of the inspection.
- There was no care plan in place to describe the ways the medication could be given. This means there was no documentation showing if the medication could be crushed or should be given as a liquid. A care plan would also describe the kind of food or liquid the medication could be given with.

A requirement is made (see requirement 2).

We saw an example where a person using the service was given medicine as a chemical restraint. This means that the person is given medication to control their behaviour. We saw that the person was prescribed two different types of medicine for this purpose. The person’s risk assessment advised the use of one and the person’s care plan advised the use of the other. We spoke to a member of staff about how the medication was to be used and their verbal account did not match with what was in the care plan. A requirement is made (see requirement 3).

Requirement 1 – Timescale: immediate on receipt of this report

- The provider must ensure that all medication is administered following the instructions of the pharmacist who dispensed it.
Requirement 2 – Timescale: immediate on receipt of this report

- The provider must ensure that all patients are given covert medication following current best practice guidance. To do this the provider must ensure that:

  (a) the person or their representative is involved in the discussions about use of covert medication. If staff believe it is not appropriate to have this discussion, the rationale must be clearly documented in the person’s healthcare record.

  (b) written advice is sought from a pharmacist about how the medication can be given safely. This advice should be sought before the first dose of covert medication is given unless it has to be given in an emergency situation. If it is given without advice of a pharmacist, then the reason for doing so must be clearly documented in the person’s healthcare record. Advice should be sought as soon as practicable after the medication is commenced.

  (c) a care plan is in place which clearly sets out how the person’s covert medications will be managed.

Requirement 3 – Timescale: by 31 October 2013

- The provider must ensure that there is a clear care plan in place when a person is subject to chemical restraint. The care plan should clearly detail:

  (a) the reason chemical restraint is required

  (b) that restraint should be used as a last resort

  (c) the situations the medicine should be used

  (d) how often the use of the chemical restraint should be reviewed, and

  (e) the type of medication which should be used. This must be consistent with what is written in the person’s risk assessment and medication prescription sheet.

Recommendation a

- We recommend that the provider should ensure that all controlled drugs are disposed of in the correct manner.

Recommendation b

- We recommend that the provider should ensure that nursing staff are able to check the expiry date of all medication that is administered from medication strips or medicine bottles.

Quality Statement 1.6

We ensure that there is an appropriate risk management system in place, which covers the care, support and treatment delivered within our service and, that it promotes/maintains the personal safety and security of service users and staff.

Grade awarded for this statement: 2 - Weak

We found that the service had a detailed and helpful policy about physical interventions and restraints. There was a system in place that was intended to ensure that risk assessments were carried out and that this would demonstrate involvement of others, including the people who use the service and/or their representative. However, this system was not being used effectively. See areas for improvement.

Staff were aware of the need to complete accident and incident forms. This meant that records were kept and could be analysed and learnt from. The service was able to produce
statistics of the numbers of incidents and accidents. This meant that there was a management overview and the potential for practice to be monitored.

Areas for improvement

We looked at the risk assessments for the use of physical and chemical restraint for two people who use the service. We saw that these had not been agreed with their legal representatives. We also found that these risk assessments had not been reviewed robustly. This meant that restraints were occurring that had not been carried out within the service’s own policy and the appropriate legal framework. We saw evidence of one incident where a person who uses the service had their liberty restricted. There was no documented assessment of why this had occurred. We did not see any evidence to support that this was the only practicable means of securing the health and welfare of the people using the service. This meant that staff were not guided by a written plan that had been suitably agreed and was in line with the service’s policy and best practice. A requirement is made (see requirement 4).

We reviewed in detail the patient care records for two people who use the service. We found that there were three folders in use and agreed goals were displayed in the service user’s bedroom. We saw these were disjointed and the documents did not match. The agreed plan of care and support was not always available to staff. Some of the information was on a computer and had not been printed off. We also saw that some of the care plans had not been agreed with the person and their legal representatives. Some parts of the care plans had not been kept up to date. This meant that there was no suitable written plan to guide and support staff in their practice. It also meant that people who use the service were not fully involved in their care plans and there was a lack of evidence of their legal representatives agreeing with the approaches and methods of managing behaviours. This must be made clearer. A requirement is made (see requirement 5).

We saw a number of issues during a walk round of the building. These included the following.

- A small pedal bin marked ‘sharps’ which was inappropriate for the disposal of sharps, such as needles. This meant staff were unable to dispose of sharps safely. This was removed by the manager during the inspection.
- Some food stuffs were found in a sluice area and again these were removed by the manager.
- A room was being used as both a domestic store cupboard and a sluice. This meant that cleaning equipment was being stored in an area where staff also disposed of body fluids.
- The domestic store cupboard and sluice did not have a clinical waste bin.
- A room which was used for people who may be distressed and may require restraint was full of inappropriate items of furniture. This would mean that staff would have to clear this out while a person was being restrained before they could use the room safely.

The infection control and environmental audits in the service had not picked these issues up. A requirement is made (see requirement 6).

There were two people who use the service whose representatives had been given legal powers. The copies of these legal orders were not stored prominently in a way that staff could easily identify who had been given specific legal powers and what these were. This meant that important decisions had not been discussed. This could have been made clearer to staff. The use of the ‘guardianship checklist’ is one format that could be considered as a method of ensuring that staff are fully aware of legal powers (see recommendation c).
Requirement 4 – Timescale: by 31 October 2013

- The provider must ensure that any restraint that takes place is the only practicable means of securing a person’s welfare and safety and the circumstances are exceptional. To do this, the provider must ensure:

  (a) there is a robust risk assessment in place that is regularly reviewed
  (b) the risk assessment and plan of care are discussed and agreed with the person using the service and any legal representatives they have, and
  (c) when restraint is used, there is a clear rationale documented in the person’s notes detailing why this was the only practicable means available to staff and the circumstances that meant restraint was necessary.

Requirement 5 – Timescale: by 30 November 2013

- The provider must ensure that every person using the service has a patient care record in place. The record must:

  (a) set out how the person’s health, safety and welfare needs are to be met
  (b) document consultation with the person who uses the service and where appropriate their representative, particularly if the representative has been granted legal powers to act on the person’s behalf
  (c) contain consistent information in all parts of the record where information about the person is held
  (d) be fully available to all staff who are involved in looking after the person who uses the service, and
  (e) be kept fully up to date.

Requirement 6 – Timescale: (a) One week after receipt of this report.
(b) Within one week of the audit being completed.

- The provider must:

  (a) conduct a full environmental and infection control audit, and
  (b) provide Healthcare Improvement Scotland with a copy of this audit along with an action plan detailing how any actions will be addressed.

Recommendation c

- We recommend that the provider should ensure that full details recorded of any legal powers held by someone who acts on behalf of a person using the service are prominently recorded.
Quality Theme 3

Quality Statement 3.3
We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Grade awarded for this statement: 3 - Adequate
We saw there is a training calendar in place in the service. Training is given in areas such as:

- epilepsy
- first aid
- continence
- infection control
- equality and diversity
- health and safety, and
- confidentiality.

The majority of staff in the service are trained to at least Scottish Vocational Qualification (SVQ) level 2. There are nine staff who are currently attending university and college gaining qualifications in areas such as nursing and psychology.

Senior staff in the service have undertaken courses in training for trainers and preparing to teach in lifelong learning. Three more staff are due to undertake teaching qualifications this year. This allows the service to improve the quality of their inhouse training.

There is a training course in the service which looks at the specifics of brain injury. Staff attend an intermediate and advanced level course depending on their role in the service.

The majority of staff we spoke with during the inspection spoke positively about their job. The staff have a diverse range of backgrounds and experience that they bring to the service.

Areas for improvement
While some of the senior staff were able to describe the model of care the service uses, the majority of other staff we spoke with were unable to do so. The model sets out the framework that the service uses to deliver the care. It is important that all staff are aware of the model used in the service as this helps them to deliver care that is consistent and guided by best practice. A requirement is made (see requirement 7).

We had been notified by the service of incidents of inappropriate practice in the service since the previous inspection. Although some staff had reported such incidents to the senior management team, we were not assured during our conversations with some staff that they were aware of what was inappropriate. We also had concerns about some of the practices regarding the restraint of people using the service and how staff protected their human rights. This is detailed in quality statement 1.6. A requirement is made (see requirement 8).

Requirement 7 – Timescale: by 31 December 2013

- The provider must ensure that the model of care being used in the service is clearly described. The provider must also ensure that all staff in the service are aware of the model and are able to describe how to put it into practice.
Requirement 8 – Timescale: by 31 December 2013

The provider must make proper provision for the health, welfare and safety of service users. In order to do so, the provider must:

(a) ensure all staff attend training on protecting a person’s human rights, and
(b) ensure all staff attend training which outlines what practices are inappropriate and details their responsibility to report this to senior staff.

No recommendations.

Quality Statement 3.4
We ensure that everyone working in the service has an ethos of respect towards service users and each other.

Grade awarded for this statement: 3 - Adequate
Graham Anderson House is a specialist service which provides care and treatment to people from across Scotland. We saw that the service receives positive feedback from agencies that refer people there for treatment.

The staff we spoke with told us they felt there had been a significant improvement in the atmosphere in the service over the last few months. They told us that the team was working together in a much more positive manner and they felt they were being treated in a more respectful manner by the management team.

We spoke with people who use the service and a relative of a person who uses the service. The feedback we received was mostly very positive. In particular, the people who use the service were very complimentary of the food.

Area for improvement
As detailed in statement 3.3, we had been notified of incidents of inappropriate practice in the service since the previous inspection. These incidents were of a nature where people who use the service were not treated with the respect we would expect. The staff involved in these incidents no longer work in the service. During the inspection, we also saw staff engage with people in a manner we did not believe was respectful. We described these incidents to the senior staff during the verbal feedback at the end of the inspection. Staff we spoke with during the inspection could not describe the ethos and culture of the service. A requirement is made (see requirement 9).

Requirement 9 – Timescale: by 31 December 2013

The provider must ensure that all staff provide services in a manner that respects the privacy and dignity of people who use the service. To do this, the provider must be able to demonstrate there are systems in place to ensure staff are not treating people in manner which does not respect their privacy or dignity.

Recommendations
No recommendations.
Quality Theme 4

Quality Statement 4.3
To encourage good quality care, we promote leadership values throughout our workforce.

Grade awarded for this statement: 3 - Adequate
Staff we spoke with during the inspection told us that they felt involved in shaping how the service develops. They felt able to approach the management team to make suggestions and felt that their suggestions would be listened to.

We saw that all staff have been given the opportunity to be involved in the service’s annual development plan.

Areas for improvement
During the inspection, we saw incidents where the nurse in charge of the ward was not taking overall control of the shift. For example, on one occasion a person using the service was subject to two episodes of physical restraint within a short period of time. During the first incident, the nurse in charge of the ward left before the restraint had been completed. They then did not know about the second restraint being carried out or why this had been necessary. It is important that the nurse in charge of the unit has full oversight of what is happening during the shift. This allows them to make sure that the care being delivered is safe and appropriate. This also allows them to fulfil the obligations of their professional registration with the Nursing and Midwifery Council (NMC). The NMC code of conduct clearly sets out that nurses must confirm that any tasks they delegate to another member of the team are completed to required standards. A requirement is made (see requirement 10).

It is important that the management team in a service of this type are fully aware of how staff engage with people who use the service. One way to do this would be to formally observe how staff interact with people who use the service (see recommendation d).

Requirement 10 – by 31 October 2013

- The provider must ensure that all qualified nurses who are in charge of a shift are fully aware of their responsibilities to have overview of the practices of all staff they are in charge of during that shift.

Recommendation d

- We recommend that the provider should ensure that the management team in the service formally observes the interactions between staff and people who use the service. This will ensure that people are being treated in a manner consistent with the culture and ethos of the service.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Quality Statement 1.4

#### Requirements

**The provider must:**

1. ensure that all medication is administered following the instructions of the pharmacist who dispensed it.

   Timescale – immediate on receipt of this report

   Regulation 3(a)

   *The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

2. ensure that all patients are given covert medication following current best practice guidance. To do this the provider must ensure that:

   (a) the person or their representative is involved in the discussions about use of covert medication. If staff believe it is not appropriate to have this discussion, the rationale must be clearly documented in the person’s healthcare record

   (b) written advice is sought from a pharmacist about how the medication can be given safely. This advice should be sought before the first dose of covert medication is given unless it has to be given in an emergency situation. If it is given without advice of a pharmacist, then the reason for doing so must be clearly documented in the person’s healthcare record. Advice should be sought as soon as practicable after the medication is commenced, and

   (c) a care plan is in place which clearly sets out how the person’s covert medications will be managed.

   Timescale – immediate on receipt of this report

   Regulation 3(a)

   *The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*
### Quality Statement 1.4 (continued)

**Requirements**

**The provider must:**

<table>
<thead>
<tr>
<th>3</th>
<th>The provider must ensure that there is a clear care plan in place when a person is subject to chemical restraint. The care plan should clearly detail:</th>
</tr>
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<tbody>
<tr>
<td>(a)</td>
<td>the reason chemical restraint is required</td>
</tr>
<tr>
<td>(b)</td>
<td>that restraint should be used as a last resort</td>
</tr>
<tr>
<td>(c)</td>
<td>the situations the medicine should be used</td>
</tr>
<tr>
<td>(d)</td>
<td>how often the use of the chemical restraint should be reviewed, and</td>
</tr>
<tr>
<td>(e)</td>
<td>the type of medication which should be used. This must be consistent with what is written in the person’s risk assessment and medication prescription sheet.</td>
</tr>
</tbody>
</table>

Timescale – by 31 October 2013

*Regulation 3(c)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

**Recommendations**

We recommend that the provider should:

| a | ensure that all controlled drugs are disposed of in the correct manner. |
| b | ensure that nursing staff are able to check the expiry date of all medication that is administered from medication strips or medicine bottles. |

### Quality Statement 1.6

**Requirements**

**The provider must:**

<table>
<thead>
<tr>
<th>4</th>
<th>ensure that any restraint that takes place is the only practicable means of securing a person’s welfare and safety and the circumstances are exceptional. To do this, the provider must ensure:</th>
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<tbody>
<tr>
<td>(a)</td>
<td>there is a robust risk assessment in place that is regularly reviewed</td>
</tr>
<tr>
<td>(b)</td>
<td>the risk assessment and plan of care are discussed and agreed with the person using the service and any legal representatives they have, and</td>
</tr>
<tr>
<td>(c)</td>
<td>when restraint is used, there is a clear rationale documented in the person’s notes detailing why this was the only practicable means available to staff and the circumstances that meant restraint was necessary.</td>
</tr>
</tbody>
</table>

Timescale – by 31 October 2013

*Regulation 3(c)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*
## Quality Statement 1.6 (continued)

### Requirements

The provider must:

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<tr>
<td><strong>5</strong></td>
<td>ensure that every person using the service has a patient care record in place. The record must:</td>
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<tr>
<td></td>
<td>(a) set out how the person’s health, safety and welfare needs are to be met</td>
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<tr>
<td></td>
<td>(b) document consultation with the person who uses the service and where appropriate their representative, particularly if the representative has been granted legal powers to act on the person’s behalf</td>
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<td></td>
<td>(c) contain consistent information in all parts of the record where information about the person is held</td>
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<td></td>
<td>(d) be fully available to all staff who are involved in looking after the person who uses the service, and</td>
</tr>
<tr>
<td></td>
<td>(e) be kept fully up to date.</td>
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Timescale – by 30 November 2013

*Regulation 4(1)*

*The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

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<td><strong>6</strong></td>
<td>(a) conduct a full environmental and infection control audit, and (b) provide Healthcare Improvement Scotland with a copy of this audit along with an action plan detailing how any actions will be addressed.</td>
</tr>
</tbody>
</table>

Timescale – (a) One week after receipt of this report. (b) Within one week of the audit being completed.

*Regulation 10(1)*

*The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

### Recommendations

We recommend that the provider should:

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<tr>
<td><strong>c</strong></td>
<td>ensure that full details recorded of any legal powers held by someone who acts on behalf of a person using the service are prominently recorded.</td>
</tr>
</tbody>
</table>
### Quality Statement 3.3

**Requirements**

**The provider must:**

- **7** ensure that the model of care being used in the service is clearly described. The provider must also ensure that all staff in the service are aware of the model and are able to describe how to put it into practice.

  Timescale – by 31 December 2013

  *Regulation 12(c)(ii)*
  *The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

- **8** make proper provision for the health, welfare and safety of service users. In order to do so, the provider must:

  - (a) ensure all staff attend training on protecting a person’s human rights, and
  - (b) ensure all staff attend training which outlines what practices are inappropriate and details their responsibility to report this to senior staff.

  Timescale – by 31 December 2013

  *Regulation 3(a)*
  *The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

**Recommendations**

None

### Quality Statement 3.4

**Requirements**

**The provider must:**

- **9** ensure that all staff provide services in a manner that respects the privacy and dignity of people who use the service. To do this, the provider must be able to demonstrate there are systems in place to ensure staff are not treating people in manner which does not respect their privacy or dignity.

  Timescale – by 31 December 2013

  *Regulation 3(b)*
  *The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

**Recommendations**

None
## Quality Statement 4.3

### Requirements

**The provider must:**

| 10 | ensure that all qualified nurses who are in charge of a shift are fully aware of their responsibilities to have overview of the practices of all staff they are in charge of during that shift. |

Timescale – by 31 October 2013

*Regulation 3(a)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011*

### Recommendation

**We recommend that the provider should:**

| d | ensure that the management team in the service formally observes the interactions between staff and people who use the service. This will ensure that people are being treated in a manner consistent with the culture and ethos of the service. |
Appendix 2 – Inspection process

Inspection is part of the regulatory process.

Each independent healthcare service completes an online self-assessment and provides supporting evidence. The self-assessment focuses on five quality themes:

- **Quality Theme 0 – Quality of information**: this is how the service looks after information and manages record keeping safely. It also includes information given to people to allow them to decide whether to use the service and if it meets their needs.
- **Quality Theme 1 – Quality of care and support**: how the service meets the needs of each individual in its care.
- **Quality Theme 2 – Quality of environment**: the environment within the service.
- **Quality Theme 3 – Quality of staffing**: the quality of the care staff, including their qualifications and training.
- **Quality Theme 4 – Quality of management and leadership**: how the service is managed and how it develops to meet the needs of the people it cares for.

We assess performance by considering the self-assessment, complaints, notifications of events and any enforcement activity. We inspect the service to validate this information and discuss related issues.

The complete inspection process is described in the flow chart in Appendix 3.

Types of inspections

Inspections may be announced or unannounced and will involve physical inspection of the clinical areas, and interviews with staff and patients. We will publish a written report 8 weeks after the inspection.

- **Announced inspection**: the service provider will be given at least 4 weeks’ notice of the inspection by letter or email.
- **Unannounced inspection**: the service provider will not be given any advance warning of the inspection.

Grading

We grade each service under quality themes and quality statements. We may not assess all quality themes and quality statements.

We grade each heading as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>excellent</td>
</tr>
<tr>
<td>5</td>
<td>very good</td>
</tr>
<tr>
<td>4</td>
<td>good</td>
</tr>
<tr>
<td>3</td>
<td>adequate</td>
</tr>
<tr>
<td>2</td>
<td>weak</td>
</tr>
<tr>
<td>1</td>
<td>unsatisfactory</td>
</tr>
</tbody>
</table>

We do not give one overall grade for an inspection.

The quality theme grade is calculated by adding together the grades of each quality statement under the quality theme. Once added together, this number is then divided by the number of statements.
For example:

**Quality Theme 1 – Quality of care and support: 4 - Good**

Quality Statement 1.1 – 3 - Adequate
Quality Statement 1.2 – 5 - Very good
Quality Statement 1.5 – 5 - Very good

Add the grades of each quality statement together, making 13. This is then divided by the number of quality statements (there are 3 quality statements), making 4.3. This is rounded down to 4, giving the overall quality theme a grade of 4 - Good.

However, if any quality statement is graded as 1 or 2, then the entire quality theme is graded as 1 or 2 regardless of the grades for the other statements.

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare service provider in relation to their improvement action plan. This will take place no later than 16 weeks after the inspection. The exact timing will depend on the severity of the issues highlighted by the inspection and the impact on patient care.

The follow-up activity will be determined by the risk presented and may involve one or more of the following:

- a further announced or unannounced inspection
- a targeted announced or unannounced inspection looking at specific areas of concern
- an on-site meeting
- a meeting by video conference
- a written submission by the service provider on progress with supporting documented evidence, or
- another intervention deemed appropriate by the inspection team based on the findings of an inspection.

Depending on the format and findings of the follow-up activity, we may publish a written report.

Appendix 3 – Inspection process flow chart

Before inspection visit

Service undertakes self-assessment exercise and submits outcome to Healthcare Improvement Scotland

↓

Self-assessment submission is reviewed to help inform and prepare for on-site inspections

↓

During inspection visit

Arrive at service

Inspections of areas

Discussions with senior staff and/or operational staff, people who use the service and their carers

Feedback with service

↓

Further inspection of service areas of significant concern identified

↓

After inspection visit(s)

Draft report produced and sent to service to check for factual accuracy

↓

Report published

↓

Follow-up activity to ensure improvement actions are completed
Appendix 4 – Details of inspection

The inspection to Graham Anderson House was conducted on Wednesday 7 and Monday 12 August 2013.

The inspection team consisted of the following members:

Gareth Marr  
Senior Inspector

Sarah Gill  
Inspector

Supported by:

Jan Nicolson  
Project Officer

Observed by:

Ross McFarlane  
Project Officer
Appendix 5 – The National Care Standards

The National Care Standards set out the standards that people who use independent healthcare services in Scotland should expect. The aim is to make sure that you receive the same high quality of service no matter where you live.

Different types of service have different National Care Standards. There are Care Standards for:

- independent hospitals
- independent specialist clinics
- independent medical consultant and general practitioner services, and
- hospice care.

When we inspect a care service we take into account the National Care Standards that the service should provide.

The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.