Unannounced Inspection Report: Independent Healthcare

The Huntercombe Services - Murdostoun Brain Injury Rehabilitation Centre

Four Seasons Health Care Properties (Frenchay) Limited | Wishaw

28–29 October 2014
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1 A summary of our inspection

About the service we inspected

The Huntercombe Services - Murdostoun Brain Injury Rehabilitation Centre is registered with Healthcare Improvement Scotland as an independent hospital. The hospital provides specialist assessment and rehabilitation healthcare services to people aged 16 years and above with a brain injury or other complex neurological conditions.

Located within the grounds of Murdostoun Castle near Newmains, the hospital is a single storey building with single room accommodation. Healthcare services are provided for up to a maximum of 21 people.

About our inspection

This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

Grades may change after this inspection due to other regulatory activity, for example if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

We carried out an unannounced inspection to Murdostoun Brain Injury Rehabilitation Centre on Tuesday 28 and Wednesday 29 October 2014.

The inspection team was made up of two inspectors: Karen Malloch and Sarah Gill, and a public partner, Gerry McKay. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them.

We assessed the service against three quality themes related to the Healthcare Improvement Scotland (requirements as to independent healthcare services) regulations and the National Care Standards. We also considered the Regulatory Support Assessment (RSA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: Not assessed
Quality Theme 1 – Quality of care and support: 2 - Weak
Quality Theme 2 – Quality of environment: Not assessed
Quality Theme 3 – Quality of staffing: 4 - Good
Quality Theme 4 – Quality of management and leadership: 2 - Weak

The grading history for Murdostoun Brain Injury Rehabilitation Centre can be found in Appendix 2 and more information about grading can be found in Appendix 4.

Before the inspection, we reviewed information about the service. We considered:

- the annual return
- any notifications of significant events, and
- the previous inspection report of 23–25 February 2014.
During the inspection, we gathered information from a variety of sources. This included:

- five patient care records
- policies and procedures
- minutes of meetings
- information leaflets about the services provided
- viewing the service’s website
- accident and incident records
- medication records
- maintenance records
- complaints, and
- menus.

We spoke with a number of people during the inspection, including:

- six patients
- one relative
- the registered manager
- consultant psychiatrist
- consultant clinical neuropsychologist
- head of therapy
- human resources and support services manager
- a charge nurse
- registered nurses
- healthcare assistants
- administration/reception staff
- maintenance staff
- a senior administrator, and
- agency nurses.

We inspected the following areas:

- north and south wards
- toilets and bathrooms
- therapy gym
- external areas, such as the entrance and paths
- medication storage areas
- domestic stores
- sluice, and
- storage areas.
What the service does well
We noted areas where the service was performing well.

- Medication management systems were well organised and storage areas are clean and tidy.
- Staff recruitment records and staff selection processes were well kept.

What the service could do better
We did find that improvement is needed in the following areas:

- listening to what clients say and using this to improve the service
- developing a team approach to care planning, and
- promoting independence skills with clients through increasing choice and opportunities.

This inspection resulted in five new requirements and ten new recommendations. Four requirements and five recommendations from the previous inspection in February 2014 have been carried forward with revised timescales. 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.

Four Seasons Health Care Properties (Frenchay) Limited, the provider, must address the requirements and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Murdostoun Brain Injury Rehabilitation Centre for their assistance during the inspection.
2 Progress since our last inspection

What the provider has done to meet the nine requirements we made at our last inspection on 23–25 February 2014

Requirement

The provider must ensure that the complaints policy is updated to make it clear to the complainant that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process.

Action taken

This requirement is reported under Quality Statement 1.1 and is not met. This requirement remains and is carried forward with a revised timescale (see requirement 1 on page 14).

Requirement

The provider must ensure that they obtain written advice from a pharmacist:

(a) on any occasion that a medication is being altered from its original form, and
(b) when medication is given mixed with any foodstuffs.

Action taken

We looked at a client’s medication record who needed to have their medication crushed. We saw that this alteration to their medication was discussed with the pharmacist and this was recorded in the client’s care record. Staff told us that when medication needs to be altered, the usual practice is to seek advice from the pharmacist and make sure this is documented. This requirement is met.

Requirement

The provider must ensure that the care planning process includes how all the identified care needs of a patient are to be met. This should include their psychological, social and spiritual needs and how to support patients who display challenging behaviours. The provider must also ensure that all care plans and risk assessments are reviewed on a regular basis to ensure the care given is appropriate to the needs of the patient.

Action taken

This requirement is reported under Quality Statement 1.5 and is partially met. The remaining element of the requirement is carried forward with a revised timescale (see requirement 3 on page 18).

Requirement

The provider must ensure that all checks are carried out within the timescale set out in the person’s care plan.

Action taken

The service currently has no clients on special observations. We saw that clients are checked regularly overnight and records showed that there were regular checks to ensure bedrails, pressure area care and breathing checks took place. This requirement is met.
Requirement

The provider must ensure that all patients who are on one to one observations are adequately supervised. To do this, they must ensure that:

(a) there is a care plan in place detailing the level of observations the patient is on and how staff should support them, and
(b) all staff are aware of the content of the care plan and carry out the observations as set out in the care plan and the provider’s policy.

Action taken
We looked at the care record of a discharged client who was on special observations (observations carried out by staff because of an individual risk assessment). We saw that observation levels were recorded in the care plan and signed off by staff. This requirement is met.

Requirement

The provider must ensure that all incidents within the service are reviewed by senior staff within a reasonable time. This will allow the service to respond to any concerns raised and ensure that any opportunities for learning are identified.

Action taken
This requirement is reported under Quality Statement 1.6 and is met.

Requirement

The provider must, having regard to the size and nature of the service, and the numbers and needs of service users, ensure that at all times suitably qualified and competent persons are working in the independent health care service in such numbers as are appropriate for the health, welfare and safety of service users.

Action taken
This requirement is reported under Quality Statement 3.3 and is not met. This requirement remains and is carried forward with a revised timescale (see requirement 6 on page 23).

Requirement

The provider must ensure that each person employed in the provision of the independent healthcare service receives regular performance reviews and appraisals.

Action taken
This requirement is reported under Quality Statement 3.3 and is not met. This requirement has been revised and is carried forward with a revised timescale (see requirement 7 on page 23).
Requirement

The provider must ensure that the framework for staff supervision is being implemented on a regular basis, with clear documentary evidence.

Action taken

This requirement is reported under Quality Statement 3.3 and is not met. This requirement has been revised and is carried forward with a revised timescale (see requirement 7 on page 23).

What the service has done to meet the 11 recommendations we made at our last inspection on 23–25 February 2014

Recommendation

The service should finalise the participation policy, including how feedback is provided to patients and relatives about changes made following suggestions they have made.

Action taken

This recommendation is reported under Quality Statement 1.1 and is not met. This recommendation remains and is carried forward (see recommendation b on page 14).

Recommendation

The service should ensure that staff follow the correct procedures when administering controlled drugs.

Action taken

Staff are now following correct procedures when administering controlled drugs. This recommendation is met.

Recommendation

The service should ensure that there is a care plan in place for all patients who are given, as required, medication to help with agitation or challenging behaviour.

Action taken

We looked at client care records and saw that care plans were in place. This recommendation is met.

Recommendation

The service should establish a risk register to identify the different risks in the service and how these risks will be managed.

Action taken

This recommendation is reported under Quality Statement 1.6 and is not met. This recommendation remains and is carried forward (see recommendation h on page 19).
Recommendation
The service should undertake an audit of the environment to identify any works that require to be carried out. The provider should then establish an action plan to ensure the necessary works are undertaken.

Action taken
This recommendation is reported under Quality Statement 1.6 and is not met. This recommendation remains and is carried forward (see recommendation g on page 19).

Recommendation
The service should ensure that the area outside the hospital is kept clean at all times.

Action taken
This recommendation is reported under Quality Statement 1.6 and is not met. This recommendation is incorporated into requirement 4 on page 19.

Recommendation
The service should ensure that there is adequate extraction in the designated smoking lounge.

Action taken
This recommendation is reported under Quality Statement 1.6 and is not met. This recommendation remains and is carried forward (see recommendation i on page 20).

Recommendation
The service should ensure that blinds are fitted in the hydrotherapy pool room and shower curtains are fitted in the changing area.

Action taken
This recommendation is met.

Recommendation
The service should put systems in place so that staff interactions with patients can be monitored and audited.

Action taken
This recommendation is reported under Quality Statement 4.4 and is not met. This recommendation remains and is carried forward (see recommendation o on page 27).
Recommendation

The service should ensure that the clinical governance meetings are re-commenced. This will allow the quality of the service to be monitored in a formal manner.

Action taken
Clinical governance meetings have taken place. This recommendation is met.

Recommendation

The service should implement the new audit process so that the quality of the service provided can be measured.

Action taken
This recommendation is reported under Quality Statement 4.4 and is not met. This recommendation is incorporated into requirement 8 on page 26).

What the provider has done to meet the five requirements we made following an upheld complaint investigation in April 2014

Requirement

The provider must ensure that proper provision is in place to ensure all patient healthcare related concerns are fully investigated.

Action taken
This requirement is reported under Quality Statement 1.6 and is met.

Requirement

The provider must ensure all nursing and therapy staff receive training and guidance on the content and application of the Adults with Incapacity (Scotland) Act 2000.

Action taken
We saw that staff had completed training on the application of the Adults with Incapacity (Scotland) Act 2000. This requirement is met.

Requirement

The provider must ensure that the care planning process includes how all identified care needs of a patient are to be met. This should include their physical, psychological, emotional, social and spiritual needs.

Action taken
This requirement is reported under Quality Statement 1.5 and is partially met. The remaining element of the requirement is carried forward with a revised timescale (see requirement 3 on page 18).
Requirement

The provider must ensure that at all times, there are sufficient numbers of suitably qualified and competent staff on duty to meet the identified needs of the patients in accordance with their patient care record.

Action taken

This requirement is reported under Quality Statement 3.3 and is not met. This requirement is incorporated into requirement 6 on page 23.

Requirement

The provider must ensure that all concerns raised by relatives are brought to the attention of the senior management team. This will allow managers to assess whether appropriate action has been taken and ensure that any opportunities for learning are identified.

Action taken

This requirement is reported under Quality Statement 1.6 and is met.
3 What we found during this inspection

Quality Theme 1 – Quality of care and support

Quality Statement 1.1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Grade awarded for this statement: 2 - Weak

Clients had some opportunities to help assess and improve the service’s quality of care and support provided, such as giving feedback on a recent brain injury awareness evening. The service has not yet fully developed opportunities to support involvement of clients with varying abilities.

Elements of a draft participation strategy were available. This contained useful guidance for staff and a number of ways that a client could get involved and provide feedback on the quality of the service.

The ‘Your Say’ forum met regularly and an invitation was extended to all clients. This was chaired by a staff member and attended by a small group of clients. We saw minutes of these meetings and saw that they gave an opportunity for clients who were able to express views to have a say. The minutes of the previous meeting were discussed and, if an action had been taken, this was recorded.

Complaints and suggestions feedback forms were available beside the main noticeboard. A box was available to put the forms into. This was only accessible to relatives and to clients who were able to reach and fill these in.

Some staff told us there had been training on complaints handling and how to record concerns and complaints. Staff were aware of the recording system for concerns and complaints. A notice was displayed in clients’ bedrooms and on the noticeboard which detailed how to give feedback. This included who to write to if dissatisfied with the service, and that they could contact Healthcare Improvement Scotland to independently assess complaints.

Training had also been provided on understanding legal issues in relation to the Adults with Incapacity (Scotland) Act 2000. Staff spoke positively about this and thought it had helped them better understand the legal implications of guardianship and power of attorney. This means clients who have lost capacity to make decisions have someone appointed who can help to represent their views and act on their behalf.

A local solicitor was available and visited the unit regularly to offer free legal advice. Their contact details were displayed on the noticeboard.

Two clients had helped to choose the curtains in the dining room. A small group of clients had also been asked about interview questions for new staff members and what sort of qualities they would look for in a staff member.

Areas for improvement

The complaints policy had not been updated in line with the requirement we made following our inspection on 23–25 February 2014. The policy in use was dated April 2011 and had some potentially confusing information about how to make a complaint. The website also had
some inaccurate information about who to complain to about Scottish services. The policy and the website should be updated (see requirement 1 and recommendation a).

The participation strategy was still in draft form and not fully implemented. There was limited reference on how to involve clients with varying levels of cognitive impairment. Staff were not familiar with the strategy and so it was not directing practice. The participation policy should be developed further and implemented (see recommendation b).

There was a lack of follow-through on some issues raised by some clients in the ‘Your Say’ forum. We saw that, in August 2014, clients had requested more snacks to be available at suppertime. The same item was recorded in each of the subsequent meetings with no action taken. Several clients told us that they were bored at times. They felt there was little to do in the evenings and sometimes during the day as well. This had also been raised by clients at ‘Your Say’ meetings, but we could see little action to make sure clients had staff support for meaningful activities outside of set ‘therapy sessions’. These examples showed a lack of listening and response by management to the views expressed by clients.

We checked a selection of client care records and found little evidence to show involvement of clients or their relatives, if appropriate, in the planning, delivery and review of their day-to-day care. A signature space was available to show that elements of care plans had been discussed and agreed with the client, but this was blank in all cases. While there are other communication strategies in place, a relative told us that a communication book was not used effectively. This meant that they sometimes felt that they were not able to express their views and be listened to.

Although the service had intended to carry out satisfaction surveys, none had been carried out in the last year. This is an important part of gaining feedback both from relatives and clients. Many clients would not be able to complete written feedback. The draft participation strategy made little reference as to how to involve clients with physical or cognitive impairment. More development was needed to gain feedback using standard methods and to develop these to be more appropriate to the client group (see recommendation c).

Requirement 1 – Timescale: by 31 January 2015

■ The provider must ensure that the complaints policy is updated to make it clear to the complainant that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process.

Recommendation a

■ We recommend that the service should update its website to be clear about how to make a complaint about this service in Scotland. Reference to the Parliamentary and Health Service Ombudsman should be removed as it is for English services.

Recommendation b

■ We recommend that the service should finalise the participation policy, including how feedback is provided to clients and relatives about changes made following suggestions they have made.
Recommendation c

- We recommend that the service should seek feedback more actively from clients and relatives, and develop methods of gaining feedback that are as inclusive as possible for clients with physical and/or cognitive impairment.

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: 4 - Good

Medication storage areas were clean and tidy, and we saw no over-stocking. Regular checks were made of fridge and room temperatures. This helps make sure medication is stored safely.

Staff confirmed the process of checking which medications were prescribed for a client on admission. The process is as follows.

- A discharge letter from the hospital lists the medications.
- This list is transcribed into the record of medicines and checked by two nurses.
- The client’s doctor then signs the list to confirm the client’s prescription in the service.
- A local GP practice generates the prescriptions.
- When the prescriptions arrive in the service, they are checked against the service’s record of what it ordered.
- Medications are supplied by a local pharmacy.

To help make sure medications prescribed are appropriate, the rehabilitation consultant carried out a weekly check of each client’s medications. Any changes to be made were then requested through the local GP service.

A weekly tablet count was carried out to check that medications had been used appropriately. This is a higher level of audit and checking than is expected or necessary.

Areas for improvement

We noted that three clients were going home at weekends on leave. However, their medication care plans had not been updated to describe the arrangements for medications and how these were to be managed at home. This should have taken place to make sure it was clearly recorded and safe for the client and their family (see recommendation d).

We asked if there had been any assessment to consider if clients could manage all or part of their own medications in the service. Although policy and risk assessments were available, none had been carried out. This meant clients were not being encouraged to manage their medication more independently. No lockable cupboards were available in client’s bedrooms to store medication in. Although there was a drawer with a lock, the keys could not be located. This meant that facilities were not in place to support self-medication. This is an important aspect of rehabilitation and should be considered (see recommendation e).
Some aspects of the medication policy did not match with practice, such as prescriptions and local ordering systems. A local standard operating procedure may be beneficial to supplement the medication policy.

Clients often had complex medication instructions with some medications being given by mouth and others by a tube directly into the stomach (gastrostomy). We noted that the service used a high number of agency staff. The care plans for giving medication were not located with the medication records on the medication trolley used for drug rounds. This could be beneficial to help unfamiliar staff to quickly see how best to administer medication for a client.

- No requirements.

Recommendation d

- We recommend that the service should ensure that clients who are away from the service on leave have their medication management needs assessed, recorded and clarified with their carers to ensure safety.

Recommendation e

- We recommend that the service should ensure staff have the training and facilities to support clients with self-medication whenever possible as part of their goal-focused rehabilitation plan.

Quality Statement 1.5

We ensure that our service keeps an accurate up-to-date, comprehensive care record of all aspects of service user care, support and treatment, which reflects individual service user healthcare needs. These records show how we meet service users' physical, psychological, emotional, social and spiritual needs at all times.

Grade awarded for this statement: 3 - Adequate

We looked at five client care records and saw that an initial assessment was carried out when a client was admitted. This included information about each client's medical history, and areas such as behavioural support needs, medication and activities of daily living, such as dressing, eating and drinking.

A number of different professionals were involved in the assessment including nurses, psychologists, a doctor and occupational therapist. We saw a range of specific assessment tools used to assess areas such as skin, nutrition and mobility.

Care plans were developed for clients when areas they needed care and support with were identified. We saw a range of care plans, nursing plans, occupational therapy plans and psychology plans. We saw that care plans were reviewed regularly and that progress notes were current, signed and dated.

Areas for improvement

While we saw that all clients had a number of current care plans in place, there was a lack of integration between teams in delivering care. For example, a client had a nursing care plan that described their hygiene care needs. We also saw an occupational therapy plan to support the client with washing and dressing as independently as possible. However, the
plans were completely separate and clinical and therapy staff referred to the separate plans when carrying out care. A joint care approach considering the needs of the person as a whole would help promote clients' independence and skills (see recommendation f).

We looked at the ‘weekly hygiene programme’. This was a tick sheet detailing clients’ names and whether they would have a wash or shower on alternate days. Staff ticked off this sheet when the task was completed. With the exception of one entry, there was no inclusion of clients’ preferences or any detail about the level of support they needed. This was very task orientated and did not show the care was person centred.

We looked at five client care records and saw their preferences for care were not recorded or included in the care plan to guide staff on delivering individualised care. We saw that the client’s preferred name could be noted, but often was not recorded. Care plans did not reflect personal choices for daily care routines (see requirement 2).

We made requirements about care plans following our last inspection in February 2014 and as a result of an upheld complaint investigation in April 2014. We saw care plans still did not include how to support clients’ emotional, spiritual or psychological needs. We noted that spiritual needs were often not assessed. From minutes of the ‘Your Say’ forum, we saw clients had raised the issue about receiving pastoral care. This had not been addressed.

We looked at the care record of a client with a known history of depression. We saw that an assessment of their mental health had not been carried out. Care plans did not include consideration of a client’s mood or mental health (see requirement 3).

The service intends to develop a case notes audit. This work should continue to provide basic monitoring for client care records.

We saw that each client had a substantial care record, but many of the forms had not been used. Staff told us a corporate suite of forms was used for all services, and that some of the forms were not appropriate for use in this service. The service’s management team told us that a review of the notes and forms was to be carried out to simplify the client care records. We saw this as a positive process. Staff told us that finding information in the client care records was difficult due to the volume and filing system.

We saw that person-centred education had taken place. Staff told us this was very useful. This should be further developed and reflected in the care planning process.

The reception area is open and, as such, is high risk in maintaining client confidentiality. We saw that client care records were kept in cupboards that were regularly open and accessible. A general client therapy programme was on display with clients’ names visible. Staff should be reminded about client confidentiality and data protection.

**Requirement 2 – Timescale: immediately from receipt of this report**

- The provider must ensure the service is provided in a way which promotes quality and safety, and respects the independence of clients by giving them choice in the way the service is provided.
Requirement 3 – Timescale: by 28 February 2015

- The provider must ensure that the care planning process includes how all the identified care needs of a client are to be met. This should include their psychological, social and spiritual needs.

Recommendation f

- We recommend that the service should ensure that clinical and therapy staff develop an effective team approach in delivering care to clients.

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: 3 - Adequate

Clients had a range of risk assessments in place including smoking, falls and pressure area care.

We saw photographs of how clients should be moved and positioned to ensure their safety and comfort. These provided very clear visual instructions to staff.

We saw that various security measures were in place such as a CCTV system that was used to review incidents. Visitors and contractors were required to sign in and out of the building.

An electronic incident reporting system was in place (Datix). We saw that incidents were followed up and investigated in a timely manner.

We saw that clients with bedrails had assessments and consent in place.

Staff carried out mandatory training in areas such as fire safety, and moving and handling.

A health and safety committee was in place and a reporting system was used to report any hazards.

Areas for improvement

We noted clients in wheelchairs or walking independently would have difficulties in moving round the external areas of the building, such as the paths. Moss was falling from the roof onto the paths and fire escape ramps. This posed a slip or trip hazard for clients. We also noted that all external areas were dirty with animal faeces (see requirement 4).

Outdoor mobility is impeded by speed bumps, the slope between units and pot holes. The area outside the front door is uneven and presents a hazard for clients and staff, particularly when they are using or pushing wheelchairs. We were told that this inhibits independent activity outside the building. No risk assessment of this area had been carried out. We were told an environmental audit had been carried out. However, we were not provided with this audit at the time of inspection and there was no action plan to show the outcome of the audit or any plans for improvement (see recommendation g).

Internally, the toilets were not appropriate for clients with mobility problems and for those who use equipment to help them. The toilets were poorly positioned and the area between
the toilets and the wall did not allow enough room for staff to assist clients when needed (see requirement 4).

While the service had some risk assessments in place, there was a lack of person-centred management of risk. For example, clients were unable to make tea or coffee or prepare their own snacks. Staff told us this was because the risk was thought to be too high. There was no risk assessment to show how this decision had been made.

The front door was locked with a security pad. Clients were unable to exit without staff unlocking the door. We were told this was because two clients were at high risk if they left the building. However, this approach restricted other clients.

All clients’ rooms had call bells. However, there was no risk assessment in place to show what would happen if a client could not use the call bell and needed help (see requirement 5).

At the previous inspection in February 2014, we recommended that the service created a risk register. The manager told us this had not yet been completed, but a risk register will be developed (see recommendation h).

We saw that many ceiling tiles needed to be replaced. We were told that, due to other maintenance work in the adjacent building, this was having an impact on works that could be carried out in the service.

At the previous inspection in February 2014, we recommended that the service should ensure there is adequate extraction in the designated smoking lounge. We saw a budget plan that includes the refurbishment of the smoking lounge in 2015 (see recommendation i).

Clients’ rooms had locked drawers that they should have been able to use as additional security to store valuables. However, no keys were available for the drawers and clients were not told how to obtain keys. Clients told us they would like to be able to lock their drawers to make sure their belongings were secure.

**Requirement 4 – Timescale: by 31 July 2015**

- The provider must ensure that the premises are suitable for the client group. To do this, the provider must ensure that the building and external areas are accessible and safe.

**Requirement 5 – Timescale: by 28 February 2015**

- The provider must ensure the service is provided in a way which ensures the safety, and respects the independence, of the clients. To do this, it must review the delivery of the service in line with the aims of rehabilitation and develop a person-centred proportionate risk management approach.

**Recommendation g**

- We recommend that the service should undertake an audit of the environment to identify any works that require to be carried out. The provider should then establish an action plan to ensure the necessary works are undertaken.

**Recommendation h**

- We recommend that the service should establish a risk register to identify the different risks in the service and how these risks will be managed.
Recommendation i

■ We recommend that the service should ensure that there is adequate extraction in the designated smoking lounge.

Quality Theme 3 – Quality of staffing

Quality Statement 3.2

We are confident that our staff have been recruited and inducted, in a safe and robust manner to protect service users and staff.

Grade awarded for this statement: 5 - Very good

We checked three staff personnel files. These contained all of the relevant checks expected to be carried out. This included:

- two references
- verification of health assessment, and
- interview notes.

Checks had been carried out to make sure staff were members of the Protection of Vulnerable Groups (PVG) Scheme. Records of these checks were held on computer. This verified the date of the check and the membership numbers held.

A retrospective checking system was also in place to make sure that all members of staff had PVG checks at least every 3 years. This system checks that staff have no new information held about them that could affect their safety to work with vulnerable adults.

A system was in place to check staff were on professional registers, such as the Nursing and Midwifery Council (NMC). Allied health professionals, such as physiotherapists, occupational therapists and psychologists were registered with the Health and Care Professions Council (HCPC). A spreadsheet was used to check that registrations were up to date.

Area for improvement

A substantial number of staff personnel files did not have copies of certificates to verify that qualifications stated had been obtained. This had already been identified by the service and certificates required had been listed on a spreadsheet. However, no action plan was in place to address this. This should be carried out (see recommendation j).

■ No requirements.

Recommendation j

■ We recommend that the service should ensure copies of certificates are requested at the point of recruitment and copies retained in staff personnel files.
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

An extensive and highly qualified multidisciplinary team was available to support and care for clients with their individual rehabilitation goals.

The team comprised of:

- rehabilitation consultant
- consultant neuro-psychiatrist
- consultant clinical neuropsychologist
- psychologist
- assistant psychologists
- counsellor
- occupational therapists
- physiotherapists
- speech and language therapist
- rehabilitation assistants
- nurses, and
- healthcare assistants.

Other support staff, such as catering assistants, housekeeping and maintenance staff were also available.

All new staff attended a brain injury awareness session. This was provided on a rolling programme. The content of the training session was continually developing.

The mandatory training programme included 13 modules for all staff to complete yearly or every 2 years depending on the subject matter. Different grades of staff also completed additional modules applicable to their role. For example, nurses completed modules about the management and administration of medications. These training modules were used across the company.

Staff were able to complete additional non-mandatory modules. This helped those staff meet their own training needs. The medical secretary monitored the online training modules completed by staff and reminders were sent to staff if needed. Completion rates were good.

Some staff had taken up group supervision opportunities. These were led by an experienced member of staff with notes taken of the meetings. Some staff also had regular individual supervision sessions. These sessions help staff with their learning, sharing of good practice and support needs.
Areas for improvement

After we talked with clients, watched staff working and examined client care records, we concluded that the multidisciplinary team’s way of working meant that opportunities for clients’ rehabilitation were limited. Clients received ‘sessions’ from staff which were scheduled from 9.30am–5.00pm. Outside of these sessions, staff did not always make sure that clients continued with their rehabilitation goals. For example, a client working to improve their hand function was not allowed to serve food or make a drink for themselves during mealtimes. The reason given was that this was ‘too risky’. However, no risk assessment was in place. Also, no care plan was in place to help the client be more independent at mealtimes.

There is much written evidence to support the view that clients’ rehabilitation should be supported over the 24-hour period. Rehabilitation goals are best practiced during every day activities such as at mealtimes, snack-times, during personal care or through the use of social activities. This was not evident during this inspection. The current style of staff working was not fully in keeping with best practice. This needs to be reviewed in order to move towards this (see recommendation k).

There was a high turnover of staff (23%), in particular with nurses. There was also a high use of agency nurses and agency care staff. This is not ideal in any care setting, but particularly in a rehabilitation setting where staff consistency is of key importance in being able to help clients to practice and review goals.

The nursing and care teams had gone through a lot of change recently. Most of the current nurses did not have formal qualifications or experience in rehabilitation. The British Society of Rehabilitation Medicine Standards for Rehabilitation Services (2009) recommend that one third of nurses in a 20-bedded rehabilitation service should have specific rehabilitation training. This would help nursing staff set goals and work effectively with the multidisciplinary team. The nurses could then improve the effectiveness of their working relationship with other teams in the service (see requirement 5 in Quality Statement 1.6 and recommendations k, l and m).

At the previous inspection in February 2014 and the upheld complaint investigation in April 2014, we made requirements about the numbers of staff on duty. Steps still need to be taken to ensure there are suitable and sufficient staff on duty with rehabilitation experience. Staff rotas showed that the number of staff on duty was not sufficient in the event of staff absence. This means that cover had to be arranged and staff continuity was still affected (see requirement 6).

Staff rotas showed that a lot of changes were made in response to sickness and absence. Low staff numbers, particularly at night, meant that sometimes 50% of staff on night duty were from an agency.

The provider had a policy which stated that staff should have regular supervision and appraisal of their work. A number of staff had not been supervised or appraised. This policy is important as it helps make sure staff have the training and support they need and that any performance issues are addressed. We will continue to follow up this requirement at future inspections to make sure that staff are supported in their work through regular performance reviews and appraisals (see requirement 7).

The current multidisciplinary team did not have a discharge co-ordinator or social worker. This is recommended by the British Society of Rehabilitation Medicine Standards for Rehabilitation Services (2009). Staff told us that there used to be a social worker, but this
post was not replaced. Key workers now carried out the duties the social worker used to. However, this impacted on their time. This should be reviewed (see recommendation l).

Rather than a ‘person (or client) allocation’ model, we saw the service used a ‘task allocation’ model. This meant that, in the morning, care staff were allocated a small group of clients to help with their personal care needs. Once that task was completed, they moved on to cleaning duties. For the remainder of the day, clients had no consistent staff support as ‘somebody from the team’ would help them. This is not best practice.

We heard staff describe clients as a ‘minimal’ client or a ‘dependent’ client. This was not respectful and was not good practice. Although staff had attended equality and diversity training, the link between theory and practice was not being checked.

Our observation of mealtimes showed that this activity was not being carried out in line with best practice. We saw no daily menu displayed. The 3-week menu cycle appeared to lack the recommended five fruit or vegetable portions a day. No drinks and snacks were available on the unit outside of set times during the day and only tea, coffee and biscuits were available at night. Clients were not offered help with washing their hands before their meal. Sauces were available in sachets, but these were difficult for clients to open. The service should provide staff training to support clients at mealtimes. Improvements are also needed to the quality of the mealtime experience, including how meals and snacks are provided. For example, we saw staff serve bread to clients, from the bread bag, using their bare hands. We also saw that one client was assisted by three different members of staff during one mealtime (see recommendations m and n).

Clinical supervision and General Medical Council (GMC) checks for medical staff could not be verified as records were unavailable. This will be checked at the next inspection.

**Requirement 6 – Timescale: by 28 February 2015**

- The provider must, having regard to the size and nature of the service, and the numbers and needs of service users, ensure that at all times suitably qualified and competent persons are working in the independent health care service in such numbers as are appropriate for the health, welfare and safety of service users.

**Requirement 7 – Timescale: by 28 February 2015**

- The provider must ensure that each person employed in the provision of the independent healthcare service receives regular supervision, performance review and appraisals.

**Recommendation k**

- We recommend that the service should develop an action plan to address the need for nurses to have training in rehabilitation.

**Recommendation l**

- We recommend that the service should consider the appointment of a discharge co-ordinator or social worker to meet the minimum staffing guidance as set out by the British Society of Rehabilitation Medicine.
Recommendation m

- We recommend that the service should review the provision of meals and snacks to ensure that this meets with best practice. The menu should be nutritionally analysed to ensure a balanced diet that includes a minimum of five portions of fruit and vegetables each day. Storage should be provided for drinks and snacks.

Recommendation n

- We recommend that the service should arrange for staff training to take place to ensure that a ‘food first’ (as opposed to nutritional supplements) approach is adopted and clients are supported to be as independent as possible.

Quality Theme 4 – Quality of management and leadership

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

Grade awarded for this statement: 3 - Adequate

We saw clearly defined leadership roles among staff. Staff knew who they reported to and who to speak to if they needed guidance or support.

Two new charge nurses had been appointed and feedback from staff was positive.

Staff attended induction and mandatory training. This included the aims and objectives of the service.

The manager was new in post and had made a commitment to be ‘on the floor’ and engage with clients and staff. We received positive feedback confirming this.

A recent employee survey had been carried out to improve staff engagement and gather views. The findings had not yet been collated, but we were told that an action plan would be developed in response to the feedback.

An employee of the month initiative was in place. We saw that this was awarded to staff who showed commitment to providing a quality service and who had a positive impact on the team.

We saw a corporate newsletter for staff called ‘Connect’ which is used to inform staff about initiatives.

Areas for improvement

There was no clear responsibility for planning and updating strategies, aims and objectives.

Action plans resulting from our previous inspection and audit action plans were not current and had not been updated since June 2014. These showed little detail about actions or timescales. Although someone was recorded as having responsibility for completing an action, there was no evidence to show any progression or overall responsibility.

The outcomes or effectiveness of care were not measured effectively. Therefore, staff delivery of care was not measured.
The service regularly used agency staff to cover sickness and annual leave. Often, agency nurses were the most senior on duty, providing little opportunity to mentor leadership in staff.

- No requirements.
- No recommendations.

**Quality Statement 4.4**

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Grade awarded for this statement: 2 - Weak

We saw that the service had a number of reporting mechanisms in place including complaints, employee surveys and accident and incident reporting.

There were opportunities for clients and families to provide feedback.

The clinical governance group or committee had developed a standard agenda to make sure there was discussion of outcomes of quality activities.

We saw minutes of site update meetings held every 3 months. These were an opportunity to improve cross-team communication.

A range of policies and procedures were in place and these were reviewed regularly.

**Areas for improvement**

While there were various mechanisms in place to measure aspects of the service, this information was not analysed for trends or gaps in provision. Although reports were generated, these only reported the number of incidents that happened, with no details of the incidents themselves. This lack of detail around incidents meant that learning from them could not take place, and patterns could not be recognised.

At our previous inspection in February 2014, we recommended that the service should improve audit activity. We saw a document that showed the outcome of various audit activity. However, we did not see the audits or action plans as they could not be located. There was no evidence of an annual audit plan. The service needs a co-ordinated approach to planning, completing and following up audit (see requirement 8).

Surveys to gather information about clients had not been carried out in the past year.

There was no clear meeting structure, schedule or indication as to how all staff groups fed into the quality system or received feedback from the various mechanisms (see requirement 8).

The service did not have a system in place to measure staff interactions with clients. Supporting communication is a very important part of caring for clients with brain injuries, and having meaningful positive exchange is an important aspect of a quality service (see recommendation 0).
The manager told us that they want to improve staff involvement in developing the service. They plan to promote staff representation at meetings and involvement in developing strategic plans and action plans.

Since our previous inspection, the clinical governance group had met once. This group should continue to meet regularly to make sure the quality of the service is formally monitored.

The National Health Services (Scotland) Act 1978 and the Healthcare Improvement Scotland (Applications and Registrations) Regulations 2011 require independent healthcare providers to notify Healthcare Improvement Scotland of specific events that occur in their premises. These events can include injury to a service user or an outbreak of infection, among others. The service has a poor notification history to Healthcare Improvement Scotland. For example, the new manager notification was not received until after the manager was in post.

Independent healthcare providers are also required to submit self-assessments to Healthcare Improvement Scotland. The self-assessment was not produced before the inspection.

No infection control lead was identified, and no system was in place to make sure infection control was in line with good practice. We saw two sluices that did not have hand washing facilities for staff. Urine bottles were not labelled for single client use. We saw that these were rinsed and not put through the sanitiser that was located in the sluice area (see requirement 9).

We saw the regulation and compliance report prepared by the clinical services manager. We noted outstanding requirements from the previous inspection report were not included in the regulation and compliance report or in response to our complaints activity. This showed a weakness in internal reporting systems to ensure that actions were taken as necessary (see requirement 8).

**Requirement 8 – Timescale: by 31 January 2015**

- The provider must ensure that any treatment or services provided by the service are of a quality which is appropriate to meet the needs of the service user. To do this, the provider must develop a system of clinical governance that gathers information from feedback and reporting mechanisms and uses this information to measure and improve the quality of the service provided.

**Requirement 9 – Timescale: by 31 January 2015**

- The provider must ensure that there are appropriate systems and processes in place for all aspects of care and treatment including infection control. To do this, the provider must:
  
  a) undertake a review of infection control management within the service including policies and procedures
  b) undertake a risk assessment of each area
  c) implement a regular audit system
  d) review staff training, and
  e) review provision of staff hand washing facilities.
Recommendation o

We recommend that the service should put systems in place so that staff interactions with clients can be monitored and audited.
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 1.1

**Requirement**

**The provider must:**

1. ensure that the complaints policy is updated to make it clear to the complainant that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process (see page 14).

   Timescale – by 31 January 2015

   SSI 2011 No. 182 - Regulation 15(6)(a)
   The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

   National Care Standards – Independent Hospitals (Standard 9.2 – Expressing your views)

   This was previously identified as a requirement in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.

**Recommendations**

**We recommend that the service should:**

a. update its website to be clear about how to make a complaint about this service in Scotland. Reference to the Parliamentary and Health Service Ombudsman should be removed as it is for English services (see page 14).

   National Care Standards – Independent Hospitals (Standard 9.4 – Expressing your views)

b. finalise the participation policy, including how feedback is provided to clients and relatives about changes made following suggestions they have made (see page 14).

   National Care Standards – Independent Hospitals (Standard 9.3 – Expressing your views)

   This was previously identified as a recommendation in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.
### Quality Statement 1.1 (continued)

**Recommendations**

We recommend that the service should:

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<tr>
<td><strong>c</strong></td>
<td>seek feedback more actively from clients and relatives, and develop methods of gaining feedback that are as inclusive as possible for clients with physical and/or cognitive impairment (see page 15).</td>
</tr>
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National Care Standards – Independent Hospitals (Standards 9.3 and 9.7 – Expressing your views)

### Quality Statement 1.4

**Requirements**

None

**Recommendations**

We recommend that the service should:

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<td><strong>d</strong></td>
<td>ensure that clients who are away from the service on leave have their medication management needs assessed, recorded and clarified with their carers to ensure safety (see page 16).</td>
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National Care Standards – Independent Hospitals (Standard 20 – Medicines management)

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<td><strong>e</strong></td>
<td>ensure staff have the training and facilities to support clients with self-medication whenever possible as part of their goal-focused rehabilitation plan (see page 16).</td>
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National Care Standards – Independent Hospitals (Standard 12.4 – Clinical effectiveness and Standard 21.5 – Allied health and social care professionals)

### Quality Statement 1.5

**Requirements**

The provider must:

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<td><strong>2</strong></td>
<td>ensure the service is provided in a way which promotes quality and safety, and respects the independence of clients by giving them choice in the way the service is provided (see page 17).</td>
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Timescale – immediately from receipt of this report

SSI 2011 No. 182 - Regulation 2

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

National Care Standards – Independent Hospitals (Standard 5 – Planning your care)
### Quality Statement 1.5 (continued)

**Requirements**

**The provider must:**

3. **ensure that the care planning process includes how all the identified care needs of a client are to be met. This should include their psychological, social and spiritual needs (see page 18).**

Timescale – by 28 February 2015

SSI 2011 No. 182 - Regulation 4(1)

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

National Care Standards – Independent Hospitals (Standard 14 – Information held about you)

This was previously identified as a requirement in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.

**Recommendation**

**We recommend that the service should:**

f. **ensure that clinical and therapy staff develop an effective team approach in delivering care to clients (see page 18).**

National Care Standards – Independent Hospitals (Standard 21 – Allied health and social care professionals)

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### Quality Statement 1.6

**Requirements**

**The provider must:**

4. **ensure that the premises are suitable for the client group. To do this, the provider must ensure that the building and external areas are accessible and safe (see page 19).**

Timescale – by 31 July 2015

SSI 2011 No. 182 - Regulation 10(2)(c)

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

National Care Standards – Independent Hospitals (Standard 15 – Your environment)
### Quality Statement 1.6 (continued)

#### Requirements

The provider must:

<table>
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<th>Requirements</th>
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| 5 | ensure the service is provided in a way which ensures the safety, and respects the independence, of the clients. To do this, it must review the delivery of the service in line with the aims of rehabilitation and develop a person-centred proportionate risk management approach (see page 19).  

Timescale – by 28 February 2015  
SSI 2011 No. 182 - Regulation 3(a)(b)  
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011  
National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness) |

#### Recommendation

We recommend that the service should:

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<th>Recommendation</th>
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| g | undertake an audit of the environment to identify any works that require to be carried out. The provider should then establish an action plan to ensure the necessary works are undertaken (see page 19).  

National Care Standards – Independent Hospitals (Standard 15 – Your environment)  
This was previously identified as a recommendation in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre. |

| h | establish a risk register to identify the different risks in the service and how these risks will be managed (see page 19).  

National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)  
This was previously identified as a recommendation in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre. |

| i | ensure that there is adequate extraction in the designated smoking lounge (see page 20).  

National Care Standards – Independent Hospitals (Standard 15 – Your environment)  
This was previously identified as a recommendation in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre. |
### Quality Statement 3.2

**Requirements**  
None  

**Recommendation**  
We recommend that the service should:  

1. Ensure copies of certificates are requested at the point of recruitment and copies retained in staff personnel files (see page 20).  

National Care Standards – Independent Hospitals (Standards 10.1 and 10.3 – Staff)

### Quality Statement 3.3

**Requirements**  

**The provider must:**

1. Having regard to the size and nature of the service, and the numbers and needs of service users, ensure that at all times suitably qualified and competent persons are working in the independent health care service in such numbers as are appropriate for the health, welfare and safety of service users (see page 23).  

Timescale – by 28 February 2015  

SSI 2011 No. 182 - Regulation 12(a)  
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011  

National Care Standards – Independent Hospitals (Standard 10 – Staff)  

This was previously identified as a requirement in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.

2. Ensure that each person employed in the provision of the independent healthcare service receives regular supervision, performance review and appraisals (see page 23).  

Timescale – by 28 February 2015  

SSI 2011 No. 182 - Regulation 12(c)(i) and (ii)  
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011  

National Care Standards – Independent Hospitals (Standard 10 – Staff)  

This was previously identified as a requirement in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.
Quality Statement 3.3 (continued)

Recommendations
We recommend that the service should:

| k | develop an action plan to address the need for nurses to have training in rehabilitation. (see page 23). |
|   | National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness) |
|   | This recommendation takes into account the British Society of Rehabilitation Medicine Standards for Rehabilitation Services (2009) (S7 - Minimum staffing provision for a district specialist in-patient rehabilitation service). |
| l | consider the appointment of a discharge co-ordinator or social worker to meet the minimum staffing guidance as set out by the British Society of Rehabilitation Medicine (see page 23). |
|   | National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness) |
| m | review the provision of meals and snacks to ensure that this meets with best practice. The menu should be nutritionally analysed to ensure a balanced diet that includes a minimum of five portions of fruit and vegetables each day. Storage should be provided for drinks and snacks (see page 24). |
|   | National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness) |
|   | This recommendation takes into account the Healthcare Improvement Scotland Food, Fluids and Nutritional Care Standards (October 2014). |
| n | arrange for staff training to take place to ensure that a ‘food first’ (as opposed to nutritional supplements) approach is adopted and clients are supported to be as independent as possible (see page 24). |
|   | National Care Standards – Independent Hospitals (Standard 12.1 – Clinical effectiveness) |
|   | This recommendation takes into account the Healthcare Improvement Scotland Food, Fluids and Nutritional Care Standards (October 2014). |
## Quality Statement 4.4

### Requirements

**The provider must:**

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| 8 | ensure that any treatment or services provided by the service are of a quality which is appropriate to meet the needs of the service user. To do this, the provider must develop a system of clinical governance that gathers information from feedback and reporting mechanisms and uses this information to measure and improve the quality of the service provided (see page 26).

    Timescale – by 31 January 2015

    *SSI 2011 No. 182 - Regulation 13(a)(b)*

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

    *National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)*

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| 9 | ensure that there are appropriate systems and processes in place for all aspects of care and treatment including infection control. To do this, the provider must:

    a) undertake a review of infection control management within the service including policies and procedures
    b) undertake a risk assessment of each area
    c) implement a regular audit system
    d) review staff training, and
    e) review provision of staff hand washing facilities (see page 26).

    Timescale – by 31 January 2015

    *SSI 2011 No. 182 - Regulation 3(d)(i)*

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

    *National Care Standards – Independent Hospitals (Standard 13 – Prevention of infection)*

### Recommendation

**We recommend that the service should:**

- put systems in place so that staff interactions with clients can be monitored and audited (see page 27).

    *National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)*

This was previously identified as a recommendation in the February 2014 inspection report for Murdostoun Brain Injury Rehabilitation Centre.
# Appendix 2 – Grading history

<table>
<thead>
<tr>
<th>Inspection date</th>
<th>Quality of information</th>
<th>Quality of care and support</th>
<th>Quality of environment</th>
<th>Quality of staffing</th>
<th>Quality of management and leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/02/2012</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
<td>2 - Weak</td>
<td>Not assessed</td>
</tr>
<tr>
<td>07/06/2012</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
<td>Not assessed</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>5 - Very good</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>Not assessed</td>
</tr>
<tr>
<td>23-25/02/2014</td>
<td>Not assessed</td>
<td>3 - Adequate</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>3 - Adequate</td>
</tr>
</tbody>
</table>
Appendix 3 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

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 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- 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. The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. 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.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on 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 hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and 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
Appendix 4 – How our inspection process works

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 Appendix 5.

**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:

- 6: excellent
- 5: very good
- 4: good
- 3: adequate
- 2: weak
- 1: unsatisfactory

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 provider in relation to the implementation of the improvement action plan. Healthcare Improvement Scotland will request an updated action plan 16 weeks after the initial inspection. The inspection team will review the action plan when it is returned and decide if follow up activity is required. The nature of the follow-up activity will be determined by the nature of the risk presented and may involve one or more of the following elements:

- a planned announced or unannounced inspection
- a planned targeted announced or unannounced follow-up inspection looking at specific areas of concern
- a meeting (either face to face or via telephone/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 the initial inspection.

A report or letter may be produced depending on the style and findings of the follow-up activity.

More information about Healthcare Improvement Scotland, our inspections and methodology can be found at: http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_healthcare.aspx
Appendix 5 – Inspection process

We follow a number of stages in our inspection process.

**Before inspection**

The independent healthcare service undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help inform and prepare for on-site inspections.

**During inspection**

We arrive at the service and undertake physical inspection.

We have discussions with senior staff and/or operational staff, people who use the service and their carers.

We give feedback to the service’s senior staff.

We undertake further inspection of services if significant concern is identified.

**After inspection**

We publish reports for patients and the public based on what we find during inspections. Healthcare staff can use our reports to find out what other services do well and use this information to help make improvements. Our reports are available on our website at www.healthcareimprovementscotland.org

We require services to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.
### Appendix 6 – Terms we use in this report

#### Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>provider</strong></td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td><strong>service</strong></td>
<td>A service is the place where healthcare is delivered by a provider. Regulated healthcare services must be registered with Healthcare Improvement Scotland.</td>
</tr>
</tbody>
</table>
We can also provide this information:

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