Unannounced Inspection Report: Independent Healthcare

Ross Hall Hospital | BMI Healthcare Limited | Glasgow
13–14 April 2016
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1 A summary of our inspection

About the service we inspected

Ross Hall Hospital, Glasgow, is part of BMI Healthcare Limited, the acute private hospital division of General Healthcare Group. Its aim is to provide the highest standards in all aspects of patient care. The hospital offers an extensive range of treatments, including cardiothoracic, colorectal, cosmetic, gastroenterology, orthopaedic surgery, plastic surgery and general surgery. Ross Hall Hospital sees both inpatients and outpatients and offers a paediatric service as required. The building is situated within a residential area, with parking available on site, close to public transport and local amenities.

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 Ross Hall Hospital on Wednesday 13 and Thursday 14 April 2016.

The inspection team was made up of three inspectors – Winifred McLure (lead inspector), Allison Wilson and Roy Young - and a public partner – Fraser Tweedie. 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 five 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:** 5 - Very good
- **Quality Theme 1 – Quality of care and support:** 5 - Very good
- **Quality Theme 2 – Quality of environment:** 5 - Very good
- **Quality Theme 3 – Quality of staffing:** 5 - Very good
- **Quality Theme 4 – Quality of management and leadership:** 5 - Very good

The grading history for Ross Hall Hospital and more information about grading can be found on our website.

Before the inspection, we reviewed information about the service. During the inspection, we gathered information from a variety of sources. We spoke with a number of people during the inspection.

What the service did well

- We saw that there was a good range of information available for patients which allowed them to be well informed about a procedure or treatment before they gave consent. The hospital had a good system in place to ensure that all patients had given consent before undergoing a treatment or procedure.
The service had very good systems to manage medication within the service with good quality assurance systems in place to minimise risks to patients.

All the equipment checked was in good repair and the service had an electronic systems in place to manage clinical and non-clinical equipment. There was also a planned programme of maintenance in place which demonstrated a proactive approach to managing the various aspects of facilities management.

On this inspection we saw good examples of promoting leadership values with clinical staff taking on the responsibility of a link nurse or champion for different areas and charge nurses undertaking the BMI Leadership Management training. We also saw good use of the corporate staff recognition scheme.

What the service could do better

- The provider must ensure that information about complaints is consistent across public facing documents in BMI Scotland sites.

- Although the service has done a lot of work in relation to laser protection, we noted that some of the information in the laser protection local rules were not in line with the guidance contained in *MHRA Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices*. The service must ensure compliance with this guidance.

- Some staff had not yet had retrospective PVG checks carried out. All staff doing regulated work must be checked through Disclosure Scotland and enrolled in the Protecting Vulnerable Groups (PVG) Scheme.

This inspection resulted in two 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.

BMI Healthcare Ltd, the provider, must address the requirements and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Ross Hall Hospital for their assistance during the inspection.
2 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 7 and 8 April 2015.

Requirement

The provider must ensure the laser protection accreditation and all the associated information is up to date and implement a system to make sure that this is reviewed on an annual basis and updated as required.

Action taken

This requirement is reported under Quality Statement 1.6. This requirement is not met (see requirement 1).

What the service had done to meet the recommendations we made at our last inspection on 7 and 8 April 2015.

Recommendation

We recommend that the service should ensure that all confidential information is stored in a secure area or lockable cupboard.

Action taken

The service ensures that all recorded information is held in an area which is constantly supervised. This recommendation is met.

Recommendation

We recommend that the service should undertake periodic observations of staff when administering medication to ensure they are continuing to do so safely.

Action taken

We saw that the service had developed a tool to undertake periodic observations of staff. This is reported under Quality statement 1.4. This recommendation is met.

Recommendation

We recommend that the service should ensure that staff know which signature sheet they must complete before they start to contribute to a patient care record.

Action taken

Although staff were aware of the signature sheets to be filled out, we noted on this inspection that some were not completed. This recommendation is not met and has been carried forward (see Appendix 1).
Recommendation

_We recommend that the service should ensure that consent forms are completed in line with its consent policy._

**Action taken**
This recommendation is reported under Quality statement 0.3. **This recommendation is met.**

Recommendation

_We recommend that the service should keep records of the daily checks of theatre equipment._

**Action taken**
We saw that daily checks were carried out and recorded. We discussed this with staff who were able to explain the procedures for this. **This recommendation is met.**

Recommendation

_We recommend that the service should undertake a risk assessment and develop an action plan to address the storage issues._

**Action taken**
We were provided with evidence of a risk assessment that was completed following our last inspection. The inspection team acknowledges that the storage of items has been reduced as much as is reasonably practicable, given the nature of the range of surgical procedures that are undertaken in the department. Senior managers are aware of the challenges in the theatre department and are working to find a permanent resolution. **This recommendation is met.**

Recommendation

_We recommend that the service should develop weekly and monthly cleaning schedules to guide theatre staff who are cleaning the clinical areas and equipment._

**Action taken**
We found that the standard of cleanliness in the theatre department was generally good. We discussed the cleaning procedures with staff and found that they had a good knowledge and understanding of these. We saw evidence of completed cleaning schedules. **This recommendation is met.**

Recommendation

_We recommend that the service should test its traceability system to ensure that it is possible to identify every patient that a surgical instrument set has been used for._

**Action taken**
This recommendation is reported under Quality Statement 1.6. **This recommendation is met.**
Recommendation

*We recommend that the service should ensure that all staff have an annual appraisal in line with the BMI Healthcare learning and development policy.*

**Action taken**

The service has taken steps to provide all staff with an annual appraisal. The recording of appraisals of all staff by department was shown to the inspectors. **This recommendation is met.**
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.2
We provide full information on the services offered to current and prospective service users. The information will help service users to decide whether our service can meet their individual needs.

Grade awarded for this statement: 5 - Very good
The service gave each potential patient information before admission. Information packs were kept in each bedroom for patients when they were admitted. Staff we spoke with told us that information about the service could be translated into other languages and interpreters were available. A Braille version could be provided if requested.

We spoke with 12 people using the service. All 12 felt they had received sufficient information and rated the quality of the information as excellent or very good in the returned questionnaires we received.

Area for improvement
The information supplied to patients before admission referred to making a complaint and Healthcare Improvement Scotland (HIS). However, the process of making a complaint was not always clear in some of the service’s documentation. Only five out of the 12 patients we spoke with knew they could make a complaint to HIS about the service. The provider should ensure that information about complaints is consistent across public-facing documents in BMI Healthcare Ltd’s Scottish services (see recommendation a).

■ No requirements.

Recommendation a
■ We recommend that the provider should ensure that information about complaints is consistent across public-facing documents in BMI Healthcare Ltd’s Scottish services.

Quality Statement 0.3
We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).

Grade awarded for this statement: 5 - Very good
In its self-assessment, the service stated that its process for obtaining consent to care and treatment reflected best practice statements and current Scottish legislation.

We found evidence to support that patient consent was obtained at all points during the care pathway with no procedure taking place without consent. The service’s operating theatres were audited every 3 months to make sure they used the World Health Organization’s (WHO) Checklist and Safer Surgery Pause.

The service’s pre-admission literature had comprehensive details of the procedure to be carried out, including risks.
All patient care records we examined showed that consent forms had been signed by the patient and consultant carrying out the procedure.

All patients we spoke with felt they had been given enough information to consent to treatment. They said:

- ‘Everything fully explained.’
- ‘Absolutely, and family kept well informed, and welcomed to come along and take notes, in case we wanted to ask questions later.’
- ‘They talked through their recommendations and the alternatives, and gave me information to take away. There was lots of guidance on how to look after myself afterwards.’

We saw good evidence that showed the patient was involved and their opinions asked for.

**Areas for improvement**

The provider was reviewing and updating its consent policy, forms and guidance. The service told us the review would take into account recent changes in the field of consent and ensure that consent is a process not an event. This will be followed up at future inspections

- No requirements.
- No recommendations.

**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: 5 - Very good**

Staff had been asked to actively encourage patients and family members to complete the service’s patient satisfaction survey questionnaire. Staff members had training in customer service.

We saw changes made from feedback received, such as buying a height-adjustable armchair for people who have had hip surgery. Televisions were replaced when patients said they looked aged.

Our public partner asked questions about patient participation, including whether the service asked patients for their comments and feedback. Of the 12 patients we spoke with, six said they had not been asked to complete questionnaires. One patient mentioned that staff regularly asked for informal verbal feedback.

The service had held one meeting with service users and representatives of several cosmetic and complimentary therapy companies. The service planned to form a service user focus group.
Areas for improvement

The service’s management team met regularly to discuss results of the patient satisfaction survey and any feedback received. However, this was not minuted and did not produce formal action plans. The service could minute this meeting and create an action plan for plans for patient participation.

- No requirements.
- No recommendations.

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: 5 - Very good

A clinical pharmacist ran an on-site pharmacy at the service. The lead pharmacist chaired a medicines management governance group which met every 2 months. We spoke with the lead pharmacist and saw evidence of medication policies, medication error reporting systems and a rolling programme of audits. Any areas for improvement identified in the audit would generate an action plan. Action plans were discussed by the medicines management governance group. The group signed off the action plan when it was satisfied the necessary improvements had been made.

The pharmacists had an overview of prescribing and checked prescriptions to ensure medicines were appropriate. The four prescription and recording charts we looked at were completed correctly. The pharmacists, or a trained member of the nursing team, spoke to patients about the use of discharge medication.

All registered nurses had completed medication training as part of their induction. The service also ran an annual face-to-face medication training day.

Medication fridges and room temperatures were regularly checked and recorded to help make sure medication was safely stored.

Patients we spoke with had all received their medications, including adequate pain relief as required and information about their medications. Patients said:

- ‘They are very good at this. If anything, there can be too much information about side effects.’
- ‘The pharmacist has been fantastic. He gives advice and offers choices.’

Areas for improvement

Policies for surgical prophylaxis had recently been developed and sent to the medical advisory committee for ratification. This will be followed up at the next inspection. We spoke with the lead pharmacist on the progress of the preparation of the hospital for the systemic anti-cancer therapy (SACT) audit. We will remain in contact with the hospital throughout this process.
No requirements.
No recommendations.

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: 5 - Very good

Staff carried out diagnostic imaging at the service, including magnetic resonance imaging (MRI), computerised tomography (CT) and X-ray scanning. We were given evidence of the radiation protection local rules. The environment was appropriate to provide these services, for example scanning rooms had restricted access and safety signage was displayed when the scanning equipment was in use. Service users also completed a safety questionnaire before they could enter the scanning room. The service also had local rules and processes in place when using lasers for eye treatments.

Staff demonstrated a very good knowledge and understanding of the policies and procedures to follow in the endoscopy decontamination unit. Staff told us they planned to begin the process for joint advisory group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale (GRS) standards.

The service had a health and safety advisor who carried out audits, attended meetings and advised staff. Minutes from recent health and safety committee meetings and clinical governance meetings recorded the issues discussed at the meetings and tracked the progress of actions to improve.

During the inspection, we checked four patient care records and saw that all relevant risk assessments were recorded. Staff we spoke with demonstrated good knowledge about managing patient risk.

Areas for improvement
We noted that some of in the information in the laser protection local rules were not in line with the guidance in Medical and Healthcare Products Regulatory Agency (MHRA) Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices (September 2015):

- The list of authorised users was not current. A number of new consultants had recently joined the service and this information had not been updated. In addition, nursing staff, who sometimes chaperone and are present in the laser treatment room during treatments, did not feature on the list.
- Staff could not demonstrate that all appropriate training had been completed.
- The adverse incidents section of the local rules did not state that all adverse incidents involving the use of lasers must be reported to MHRA.
- Written treatment protocols were not available. These describe the different treatments that can take place using the lasers.

The service must adhere to the MHRA guidance (see requirement 1).
We reviewed some of the theatre department’s quality assurance checks. Staff verbally described the process for tracking and traceability of instrument trays. Following our last inspection, we saw evidence of a tracking and traceability audit that had been completed for two instrument sets. However, we saw no evidence to show a programme of audits for tracking and traceability had been introduced. We were told the service planned to complete this yearly (see recommendation b).

Although staff had a very good knowledge of the endoscopy unit’s policies and procedures, no documented daily traceability audits had been completed for March 2016. This was reported to the service who re-commenced daily tractability audits. We will follow this up at future inspections

Requirement 1 – Timescale: by 30 August 2016

- The provider must ensure that appropriate systems processes and procedures are in place for the use of lasers and intense light source equipment, taking account of the guidance contained in the MHRA Lasers, intense light source systems and LEDs - guidance for safe use in medical, surgical, dental and aesthetic practices (September 2015).

Recommendation b

- We recommend that the service should ensure that an annual documented tracking and traceability audit for instrument trays is carried out.

Quality Theme 2 – Quality of environment

Quality Statement 2.2
We are confident that the design, layout and facilities of our service support the safe and effective delivery of care and treatment.

Grade awarded for this statement: 5 - Very good

The hospital’s design supported safe care and was clean, tidy and in a reasonable state of repair. All of the bedrooms were ensuite and had a television, telephone and nurse call button. If a patient could not use the bath, rooms with floor-level showers were available. The hospital was equipped to support patients and visitors with disabilities. On-site car parking was available with spaces reserved for ‘blue badge holders’ near the entrance. Lift access was also available.

All equipment we checked was in good repair and the service had an electronic systems in place to manage clinical and non-clinical equipment. We saw servicing and maintenance records for non-clinical equipment and agreements with external contractors to service and maintain the service’s other equipment and systems. We found the management systems in place were robust and well organised.

A planned programme of maintenance was in place, which demonstrated a proactive approach to facilities management. The service had comprehensive systems to manage some complex areas of the service, such as water safety and fire safety. External specialist companies provided input for regular site inspections and assessments.
Areas for improvement

Windows in wards were in a poor state of repair. While we were told the service planned to refurbish the windows, this was subject to funding. We will follow this up at future inspections.

Corridor areas of the wards were carpeted, which is not ideal for infection prevention and control. The service had carried out a risk assessment for this and identified the carpet to be replaced as part of a planned refurbishment programme. We will follow this up at future inspections.

Staff could use clinical hand wash basins in patient bedrooms to wash their hands before and after delivering care. The service had carried out a risk assessment which concluded that clinical hand wash sinks could not be installed in patient bedrooms due to a lack of space. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Quality Statement 2.4

We ensure that our infection prevention and control policy and practices, including decontamination, are in line with current legislation and best practice (where appropriate Scottish legislation).

Grade awarded for this statement: 5 - Very good

The service’s infection control committee was made up of key staff from the service. Infection prevention and control was also a standing agenda item at clinical governance meetings and we saw evidence that infection prevention and control was discussed at both meetings. The majority of staff had completed their yearly mandatory online infection prevention and control training module. A process to identify staff who had not completed training was in place and a training tracker easily identified training gaps.

We saw evidence of regular audits, including hand hygiene compliance and infection prevention society audits. We saw that actions were taken when deficiencies were found.

Staff had a good knowledge and understanding of infection prevention and control policies and procedures.

Service users, visitors and staff had good access to alcohol-based hand rub to decontaminate their hands. Patients told us:

- ‘The staff always use the hand gels.’
- ‘The visitors are actively encouraged to use the hand gel.’

Standards of cleanliness in the service was very good. Systems to identify the cleaning required and record the work carried out were in place. We saw housekeeping checklists used for cleaning patient bedrooms. We also saw that clinical staff had a system of cleaning equipment daily, weekly and monthly. Patients told us:

- ‘There is not a spot of dirt anywhere. I ran my finger along the top of the TV.’
‘Spot on. They are always cleaning.’
‘It is always clean and fresh.’

Areas for improvement
We were told that the infection prevention and control lead nurse in the service reported to the Director of Nursing as the site Director of Infection Prevention and Control. Any issues if required could then be raised with the Groups senior infection prevention and control lead nurse who sits on the Senior Leadership team. The Scottish hospitals have a dedicated Consultant Microbiologist who holds a substantive post in the NHS as the Professor of Microbiology. He is a member of The Medical Advisory Committee and attends the quarterly Infection Prevention and Control Meetings and provides advice and direction on all infection prevention and control issues across the Scottish hospital sites.

The infection prevention and control (IPC) lead nurse in the service at Ross Hall holds a formal qualification in infection prevention and control. This lead nurse advises and supports two infection prevention and control lead nurses from two of the provider’s other Scottish services within the Central Scotland Cluster, Carrick Glen Hospital and Kings Park Hospital. However they do not line manage these staff. These staff currently do not hold a formal qualification in infection prevention and control, however the IPC lead at Kings Park is currently working towards a post graduate qualification in infection prevention and control.

The same infection prevention and control lead nurse provides advice and support to the provider’s other Scottish services alongside the Professor in microbiology. Regional infection prevention and control meetings were held at the service and included all IPC lead nurses in Scotland and each of the sites director of infection prevention and control but there was no senior infection prevention and control lead nurse present.

The provider should review the structure and qualifications of the infection prevention and control lead nurses in Scotland to ensure that they are in line with the requirements of the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015 (see recommendation c).

We were told that the service has not completed a formal review of the service against the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015. The Lead IPC Nurse and the DON/DIPC undertook a review of the Standards to set priorities for the coming months. The service should carry out this review to make sure it is in line with the standards (see recommendation d).

The infection prevention and control lead nurse told us they had recently reviewed the service against the Vale of Leven Report’s recommendations, to identify learning. However, there was no formal record of this. The service could consider recording any reviews to evidence improvement in practice.

We found some evidence of infection prevention and control audits taking place using Infection Prevention Society (IPS) audit tools. However, these tools did not cover all aspects of standard infection control precautions in line with the Health Protection Scotland National Infection Prevention and Control Manual. We will follow this up at future inspections.

Recommendation c
We recommend that the provider should review the structure and qualifications of the infection prevention and control lead nurses in Scotland to ensure that they are in line with the requirements of the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015.
Recommendation d

- We recommend that the service should complete a formal review of the service against the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015. This will identify any relevant learning for the service.

Quality Theme 3 – Quality of staffing

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: 5 - Very good

An induction package was in place with a period of probation for new staff. All nurse, doctor and allied health professionals’ registrations were checked and recorded using an online verification system. A system was in place to check these yearly.

The service only held consultants’ human resource files. The four files we examined had all recently been given practicing privileges at the hospital and all had up-to-date PVG checks and public liability insurance.

We asked the trained nurses about mandatory training and training opportunities. They agreed that they had adequate training and could ask for and access other training needs. The regional clinical educator told us that training plans were ongoing and training was well attended. Training was a mix of online and hands-on approaches.

The service gave us evidence of completed annual appraisals, along with completion rates. Over 90% of annual appraisals were completed. This was a significant improvement from our previous inspection.

Of the 12 patients we asked to rate the quality of care and treatment being provided, 10 patients said it was excellent, and two said it was very good. Patient comments included:

- ‘No complaints at all.’
- ‘It’s their professionalism, and the time they spend with you, telling you what’s happening.’
- ‘Good staff, and doctors explain everything.’
- ‘All the staff are courteous and very informative.’

Area for improvement

The majority of consultants who had been in the service for some time had not been checked to see if they were enrolled in the PVG scheme. The provider, BMI Healthcare Ltd, has UK-wide corporate policies and protocols. This had led to some responsible medical officers having criminal record checks being carried out under a system used in England and Wales. The service must ensure that all staff undertaking regulated work in Scotland are enrolled in the PVG Scheme (see requirement 2).

Requirement 2 – Timescale: by 30 August 2016
The provider must ensure that all staff carrying out regulated work are enrolled in the Protecting Vulnerable Groups (PVG) Scheme.

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: 5 - Very good

In its self-assessment, the service stated that the organisation expected very high standards of customer care. The service had set a clear expectation supported by polices, protocols, guidance and legislative standards which will enable staff to meet and demonstrate them.

The provider made sure each area had a copy of the National Care Standards for Independent Hospitals. All clinical areas had a copy of the Nursing and Midwifery Council code of professional standards.

The service had provided equality and diversity, customer care and delivering difficult messages training. Staff appraisals were carried out regularly. Staff interactions with patients and each other formed an important part of the appraisal.

Staff we spoke with were positive about communication, inclusion and the perception of being valued. Regular staff supervision and appraisals showed evidence of this. We saw a person–centred, compassionate and thoughtful approach to patient care in the service, with all staff we spoke with told us they would raise a concern if they observed any practices not in the best interests of patients.

Staff told us they had good working relationships with their peers, communication was good and they felt supported by their managers. Staff told us they took the lead in some clinical areas, such as infection control and blood transfusion. They would then attend regular team meetings as the lead for this area.

All 12 patients our public partner interviewed said they were treated with dignity and respect. Comments included:

- ‘Very much so. It’s like a 5-star hotel. Lots of small details are attended to. If anyone complains about them, I would punch them in the nose!’
- ‘Definitely. All the time.’
- ‘The staff are really nice and friendly. I feel they have a ‘calling’ for their job.’

Areas for improvement

The service had a caring behaviours framework called ‘the 6Cs’. However, some staff we spoke with were unsure of the behaviours framework and how that impacted on their daily work. The service could address this issue, through specific training sessions or as part of discussions in staff forums and departmental meetings to make the 6Cs more relevant to staff’s daily work.

No requirements.
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: 5 - Very good
We saw good examples of promoting leadership values. All staff had up-to-date appraisals with a personal development plan and objectives in place. Clinical staff took on the responsibility of a link nurse or champion for different areas. Five charge nurses were completing BMI leadership management training and it was planned that all charge nurses would complete this training.

From clinical governance and senior management team meetings, we saw that senior staff had clear areas of responsibility for actions. Two senior staff were now on the corporate clinical governance committee. A morning communication huddle was attended by key staff. This morning huddle discussed the 24 hours before and after, highlighting any areas of concern. This information was then fed back to other departments.

The executive director held open forums to disseminate information, including the aims and objectives of the organisation. The executive director also set up and chaired an informal communication group to allow members to discuss any issues. The new format of the group intended to encourage open and transparent discussions.

The service ran a staff recognition scheme called ‘Above and Beyond’ which encourages staff and patients to nominate staff for an award when staff go beyond what is expected of them in their daily work, either by supporting patients, supporting staff or improving the service. Staff were encouraged to recognise and celebrate success. The executive director ran the local scheme and the provider ran the same scheme corporately across all its services.

Staff we spoke to were clear about their areas of responsibility and the about how this fitted in with the leadership arrangements within the service.

- ‘There is a clear structure in place’
- ‘You know who to go to if you have an issue’

Area for improvement
A staff survey had recently taken place but no results were available for the inspection team to view. We will follow this up at future inspections.

- 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: 5 - Very good

The service had been unable to submit a new self-assessment to Healthcare Improvement Scotland due to a problem with the online system they use to complete it. This self-assessment is completed by the service each year and provides a measure of how the service has assessed themselves against the quality themes and national care standards. In 2015, the service had submitted a comprehensive self-assessment and we found good quality information that we were to verify during this inspection.

We saw that the service had good quality assurance systems in place which included senior management meetings, the medical advisory committee and the clinical governance group. The clinical governance group minutes showed that this group oversaw reports from various subgroups including medicines management, infection prevention and control. Other issues discussed at the meeting included accidents and incidents, complaints and staff training. All information was analysed for trends and actions were agreed and planned.

Accidents and incidents were monitored and discussed at the 'lessons learned' meeting. This highlighted staff awareness of risks and ensured changes were made if required to maintain patient safety.

The service had introduced a new online audit planner and tracker. The provider had set a rolling programme of audit activity, which included auditing medication records, risk assessments for blood clots and infection control. The results of these were discussed at the clinical governance group and action plans agreed.

The service used a complaints log to record details of complaints received. The complaints log showed:

- the details of the complaint
- the outcome of the complaint, and
- whether it was resolved satisfactorily.

Areas for improvement
The use of the new online audit planner and tracker was still being embedded with the service. As well as managing audits, the system was also able to produce action plans. However, this had not yet been used and the service still produced its own action plans. The risk register was also changing to a new format. We will follow up the progress of these new electronic systems and processes at future inspections.

- No requirements.
- No recommendations.
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 0.2

**Requirements**

None

**Recommendation**

We recommend that the service should:

a. ensure that information about complaints is consistent across public-facing documents in BMI Healthcare Ltd’s Scottish hospital sites (see page 9).

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

### Quality Statement 1.6

**Requirement**

The provider must:

1. ensure that appropriate systems processes and procedures are in place for the use of lasers and intense light source equipment, taking account of the guidance contained in the *MHRA Lasers, intense light source systems and LEDs - guidance for safe use in medical, surgical, dental and aesthetic practices (September 2015)* (see page 13)

Timescale – by 30 August 2016

Regulation 3 (d) (v)

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

National Care Standards – Independent Hospitals (Standard 15.5– Your Environment)

**Recommendations**

We recommend that the service should:

b. ensure that an annual documented tracking and traceability audit for instrument trays is carried out (see page 13).

National Care Standards – Independent Hospitals (Standard 13.2 – Prevention of
Quality Statement 2.4

Requirements

None

Recommendations

We recommend that the service should:

1. review the structure and qualifications of the infection prevention and control lead nurses in Scotland to ensure that they are in line with the requirements of the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015 (see page 15). National Care Standards – Independent Hospitals (Standard 13.2 – Prevention of infection)

2. complete a formal review of the service against the Healthcare Improvement Scotland Healthcare Associated Infection Standards 2015. This will identify any relevant learning for the service (see page 15). National Care Standards – Independent Hospitals (Standard 13.2 – Prevention of infection)

Quality Statement 3.3

Requirement

The provider must:

2. ensure that all staff undertaking regulated work are enrolled in the Protecting Vulnerable Groups (PVG) Scheme (see page 16).

Timescale – by 30 August 2016

Regulation 9

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

National Care Standards – Independent Hospitals (Standard 10.3 – Staff)

Recommendations

None

Recommendation carried forward from our 7–8 April 2016 inspection

We recommend that the service should:

ensure that staff know which signature sheet they must complete before they start to contribute to a patient care record.
| National Care Standards – Independent Hospitals (Standard 14.3 – Information held about you) |
Appendix 2 – 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: comments.his@nhs.net
Appendix 3 – 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   5   4   3   2   1
excellent  very good  good  adequate  weak  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:
Appendix 4 – Inspection process flow chart

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](http://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 5 – Terms we use in this report

Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>provider</td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td>service</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.

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Gyle Square
1 South Gyle Crescent
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www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium (SMC) are part of our organisation.