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1 A summary of our inspection

About the service we inspected

Spire Murrayfield Hospital is registered with Healthcare Improvement Scotland as an independent hospital to provide medical and surgical inpatient and outpatient services to adults and children.

The hospital is part of Spire Healthcare Ltd, the UK-wide independent healthcare group. The service provides a range of medical and surgical services, including treatments for cancer.

The hospital has 70 inpatient beds divided into two wards. The ground floor ward is used for patients who need more complex surgery. The first floor ward is used for day care and short-stay treatments. The patient rooms are all single rooms with ensuite shower or bath facilities. A 3-bedded high dependency unit (HDU) is also available for patients who need a higher level of care. Beechwood House contains additional outpatient consulting rooms, a laser treatment room and physiotherapy service. A single storey modern building houses the wellness centre where general health check-ups are provided.

Spire Murrayfield Hospital is situated in the Murrayfield area of Edinburgh close to public transport services. The hospital is set in pleasant grounds and car parking is available.

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 Spire Murrayfield Hospital on Wednesday 12 and Thursday 13 August 2015.

The inspection team was made up of two inspectors and a public partner. 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. For a full list of inspection team members on this inspection, see Appendix 6.

We assessed the service against all 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 Spire Murrayfield Hospital 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
- the previous inspection report of 19 and 20 August 2014, and
- complaints activity.

During the inspection, we gathered information from a variety of sources. This included:

- results of the inpatient questionnaire
- information leaflets about the hospital’s services
- five patient care records (to check risk assessment, consent forms and theatre checks)
- medication systems
- various policies and procedures
- the asset register and maintenance checks
- theatre cleaning records
- five staff files
- staff rotas
- the induction framework
- the training plan
- registration checks for all staff groups
- the complaints log
- the accidents and incidents log
- clinical governance systems
- audit records, and
- minutes of clinical governance meetings and clinical effectiveness meetings.

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

- the administration manager
- the clinical governance co-ordinator
- an engineer
- healthcare assistants
- the human resources and training co-ordinator
- the management support and compliance manager
- the matron
- the nursing serves manager
- a radiographer
- a physiotherapist
- the senior medical records administrator
- senior staff nurses
- staff nurses, and
• the theatre manager.

We inspected the following areas:

• the inpatient wards
• the outpatient department
• the oncology day unit
• the wellness centre, and
• Beechwood House.

What the service did well

• The service was able to show a well-thought out and extensive programme of engagement that gave patients many opportunities and different ways to improve many aspects of the service.
• The service was delivered from premises which were well maintained and of a high decorative standard. They were also well laid out and supported the safe delivery of care. The overall maintenance and refurbishment plans recognised risk to both patients and staff and would ensure safe delivery of care for patients.
• The service had a robust clinical governance system in place to monitor the quality of the service. We saw that, if areas for improvement were identified, clear actions were in place to address these.

What the service could do better

• Spire Murrayfield Hospital should improve the systems in place to verify the cleaning that is undertaken by healthcare staff on the wards.
• Spire Murrayfield Hospital should ensure a consistent approach to managing staff personnel files.

This inspection resulted in four recommendations (see Appendix 1 for a full list).

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

What the provider had done to meet the requirement we made at our last inspection on 19 and 20 August 2014

Requirement

The provider must ensure that risk assessments are used to determine the safety for individual patients to use stand-alone heaters.

Action taken

Risk assessments had been developed for stand-alone heaters. We saw that these were available in the staff office for use when required. At the time of the inspection, none were being used. This requirement is met.

What the service had done to meet the nine recommendations we made at our last inspection on 19 and 20 August 2014

Recommendation

The service should review its ‘Please talk to us’ information leaflet to include the correct contact details for Healthcare Improvement Scotland. This will guide patients to Healthcare Improvement Scotland if they want to make a complaint.

Action taken

We saw the information leaflet had been updated and included the correct contact details for Healthcare Improvement Scotland. This recommendation is met.

Recommendation

The service should develop a formal patient and relative’s participation policy.

Action taken

The service was able to demonstrate good evidence of its participation and engagement activity. The marketing department was able to evidence the work it had done so far this year and showed us an outline plan for the remainder of the year. However, the service had not developed a participation policy. This is reported under Quality Statement 1.1. This recommendation is not met (see recommendation a).

Recommendation

The service should develop the medication policy to include two sources to verify prescription of patients’ own medication and provide a place for this to be recorded.

Action taken

The medication policy had been updated to include medication reconciliation verification from two sources. This recommendation is met.
Recommendation

The service should ensure that all swab, needle and instrument counts are recorded in the theatre register.

Action taken

We saw that records were now kept to evidence that all swab and needle counts took place. We saw that a new record book had been developed and implemented. This allowed theatre staff to record that all counts before, during and at the end of a procedure took place. There was space for this to be signed off by the scrub nurse and the practitioner. In the event that the count at the end of the procedure does not match the start count, there was space in the record to document the subsequent steps to locate the item that was unaccounted for. A copy of the record was kept in the theatre department. A copy was also kept in the patient care record. This recommendation is met.

Recommendation

The service should ensure that all incidents and near misses are recorded on Datix to ensure learning points are identified.

Action taken

The service had provided education to staff about the importance of incident and near miss reporting. Staff we spoke with confirmed they followed procedures. Lessons learned from incidents were communicated to staff through meetings. Staff had recently been provided with additional access to the Datix system to allow them to see the outcome of investigations. This recommendation is met.

Recommendation

The service should keep detailed records of the additional weekly and monthly checks and maintenance of the anaesthetic machines along with the serial numbers of circuits as they are replaced.

Action taken

We saw that new documentation had been implemented in each of the four theatres to record the daily checks that were carried out. These new documents allowed staff to record all day-to-day checks, such as the replacement of the soda lime canisters and the serial numbers of the circuits when they were replaced. This recommendation is met.

Recommendation

The service should enclose the shelving in the ground floor sluice room to improve the control of infection.

Action taken

While the sluice room on the ground floor was awaiting a significant refurbishment, we saw that doors had been refitted to the cupboard and the shelving was now enclosed. This recommendation is met.
**Recommendation**

*The service should develop daily, weekly and monthly cleaning schedules to guide clinical staff who are cleaning the clinical areas and equipment and develop a system of checking this.*

**Action taken**

We saw that the patient equipment cleaning schedules for clinical staff had been updated and revised a number of times since the last inspection. Both inpatient wards now used the same cleaning schedule as a result of the most recent revision. However, we saw that while records were available for each week, they were not fully completed every day. This is reported under Quality Statement 2.2. **This recommendation is partially met** (see recommendation b).

**Recommendation**

*The service should ensure that staff practices are clinically effective and any practice which is not should be challenged and such challenges supported.*

**Action taken**

The service had been auditing venous thromboembolism (VTE) interventions. Practice was in line with Scottish Intercollegiate Guidelines Network (SIGN) recommended best practice. The use of antibiotics was closely monitored and these were only prescribed if clinically indicated. **This recommendation is met.**
3 What we found during this inspection

Quality Theme 0 – Quality of information

<table>
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<tr>
<th>Quality Statement 0.3</th>
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<tr>
<td>We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).</td>
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Grade awarded for this statement: 5 - Very good

Clear policies and procedures were in place to ensure that consent was obtained from patients before medical investigations and surgical procedures.

Patients were provided with specific information relevant to their situation. This information was given before admission to hospital and included detailed information on the procedures they had been admitted for. We saw a comprehensive consent form was in place. The consent form included the procedure to be carried out and the intended benefits and risks associated.

We looked at five patient care records. We found appropriate consents in place signed by the patient. We noted that the consent form requires doctors to confirm that the procedure had been fully discussed with the patient. We saw that this conversation was documented on the consent form and also recorded in the nursing documentation. Patients can have a copy of the consent forms for their own records if they wish.

Consents forms were available for both adults and adults with incapacity. We saw records that confirmed staff had carried out vulnerable adults training.

We saw a ‘do not attempt cardiopulmonary resuscitation order’ (DNACPR) was completed in one patient’s notes. Staff were aware of this patient’s instructions.

Completion of consent forms was monitored through the audit programme. We saw results were good and any gaps were addressed.

Area for improvement

Spire Healthcare Ltd was reviewing its consent policy at the time of the inspection to reflect Scottish legislative requirements. We were told that the draft policy would be available for implementation on 20 August 2015.

- No requirements.
- No recommendations.
Quality Statement 0.4

We ensure that information held about service users is managed to ensure confidentiality and that the information is only shared with others if appropriate and with the informed consent of the service user.

Grade awarded for this statement: 5 - Very good

We saw that the service had a clear and easy to read data protection notice which forms part of the patient registration process. The notice tells patients that the service will keep their personal information confidential, but that there are circumstances when it is necessary for it to be shared. For example, with:

- their GP
- other healthcare professionals and teams outside the service that are involved in their care
- appropriate members of staff within the Spire Healthcare Ltd group in order to deliver their care, and
- their insurance company.

We saw that the service had access to the current Spire Healthcare Ltd policy on patient care records. This was last reviewed in 2013 and was due for a further review in 2016. The policy covered all aspects of patient care records, including:

- record management systems
- training needs for staff
- confidentiality
- patient access to records
- retention schedules, and
- destruction.

During the inspection, we saw how staff managed patient care records. We saw that staff did not leave records unattended when they were in use. They returned the patient care records to the ward office when they were not in use. We saw that the office was locked when no-one was working in there. Once patients were discharged, their records were transferred to the secure storage facility in the basement of the hospital. We also saw that records were well managed in other areas of the hospital too, such as the outpatients department, the wellness centre and the physiotherapy department. A system was in place to book patient care records in and out of the store and track which department had requested them. The service also had access to the provider’s secure off-site archive facility. Records that were no longer in active use in the hospital (had not been requested for 6 months) were sent there for storage, until they were needed again or they could be destroyed.

Staff we spoke with were aware of the importance of information security and understood their role and responsibility for keeping patient information safe and secure. All staff were required to carry out information governance training as a part of their induction.

Spire Healthcare Ltd had appointed its medical director as the Caldicott Guardian. The Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient
and service user information and enabling appropriate information sharing. The hospital
director had local responsibility for information governance.

- 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
The service was able to provide evidence of a wide variety of activities which allowed
prospective, current and past patients to participate in all aspects of the development of the
service.

The provider had recently changed its approach to seeking views from patients. Instead of an
annual patient satisfaction survey, an inpatient satisfaction survey was given to every patient
when they were discharged from the service. These were then sent to an independent
company for collation and analysis. We saw that the service received a report on the results
of the survey every month. The survey asked patients about the quality of:

- the overall service provided by the hospital
- the environment
- various aspects of their hospital stay (including making a reservation, how prepared they
  were for their stay, the admission process and preparations for their return home), and
- the staff (including doctors, nurses, theatre staff, imaging staff, pharmacists and the hotel
  services team).

The survey also asked if:

- patients were treated with dignity at all times
- patients had enough privacy during their stay
- patients had enough opportunity to be involved in their care, and
- the hospital staff did all they could to control pain.

Results of the most recent survey report showed high levels of satisfaction. In almost all
cases, the service was rated ‘very good’ or ‘excellent’. The reports also included comments
from patients from the survey responses. We saw that where a negative experience or an
area for improvement was suggested, these were followed up by the hospital management
team.

Outpatients were not included in this new approach to the satisfaction survey. As a result, the
service had developed its own outpatient survey to allow patients who use these services an
opportunity to comment. This survey was new and we will review how successful it has been
at the next inspection.
The service had many information leaflets available for patients covering a wide variety of topics. As part of the development and review process for these leaflets, current and former patients were contacted for their views on the content. We saw evidence that patient feedback had been sought for, and responded to, for the following information leaflets:

- varicose veins
- foot and ankle surgery, and
- breast reduction surgery.

The service ran a number of focus groups over the year. These were used to inform improvements in the service. We saw evidence of the last two sessions that had been held. These had focused on particular specialties: endoscopy and cosmetic surgery. While these were an opportunity to get general feedback from patients on their experiences of using the service, they were primarily run to seek views on a particular issue. For example, the cosmetic surgery focus group was looking at new post-operative care leaflets that were being developed at the time. Feedback from the focus groups was written up and shared with staff across the hospital. Each team had their own version of the feedback which focused on the issues that were relevant to them. The service was planning another one or two sessions this year.

The service had a very active presence on a social media site. The service page had a large following and had become a valuable two-way tool for the service and patients to communicate with each other. We saw numerous examples of where the service was complimented and where the service had responded to issues that had been raised through this channel. We saw that users of the site rated the service very highly.

**Area for improvement**

Although we saw very good evidence of the participation activities the service had been doing, it had not developed a formal participation policy. The marketing department had an outline work plan for the year. This detailed planned events for patients to get involved in the development and improvement of the service. We believe this goes some way to meeting this recommendation. The service should build on the marketing department’s outline work plan and develop a formal document that sets out planned participation activity, the expected outcome and a measure for effectiveness (see recommendation a).

- No requirements.

**Recommendation a**

- We recommend that the service should build on the marketing department’s outline work plan and develop a formal document that sets out planned participation activity, the expected outcomes and a measure for effectiveness.
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: 5 - Very good

Before admission to hospital, patients were required to complete a medical questionnaire. This provided the hospital with information about the patients’ past medical history, family contacts, specific dietary requirements and allergies. During the inspection, we checked five patient care records. We found very good standards of record-keeping. All aspects of patients’ care were considered.

The hospital used a care pathway for patients. A care pathway is the care that is planned for a patient during their stay and includes clinical interventions and milestones placed in an expected timeframe, written and agreed by a multidisciplinary team. It had locally agreed standards to help a patient with specific conditions. We looked at care pathways for medical conditions, breast augmentation and hip replacements. We saw that these were completed, signed and dated. Supplementary notes were added when additional narrative was required.

We saw a range of risk assessments in patients’ care records. These included assessment of falls risk, moving and handling, dietary and pressure area risk. We also saw risk assessment for venous thromboembolism (VTE). This is a blood clot that forms within a vein.

The following were also included in the patient care records:

- consent to treatment form
- consent to use bedrails
- anaesthetists’ records
- medication record charts
- physical observational records
- pre-operative checklists, and
- surgical safety checklists.

Area for improvement

The service identified that it was planning to improve monitoring of documentation through the introduction of peer review. This would include nursing and medical staff who would sample each other’s notes for content and quality.

- No requirements.
- No recommendations.
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 service is a large general hospital. As well as a 70-bed inpatient unit, it also has:

- a high dependency unit (HDU)
- four operating theatres
- outpatient consulting rooms in the main hospital building and Beechwood House
- a physiotherapy department
- a health centre for general health check-ups
- a chemotherapy day unit, and
- an imaging department.

During the inspection, we looked in two of the patient bedrooms. We saw that they were clean and tidy. Both bedrooms had:

- an ensuite shower or bath
- a television and telephone
- WiFi
- a locker, and
- a patient information book.

One of the bathrooms we looked at had been refurbished to a very high standard. The other one was still to be completed. As part of the refurbishment, the old baths had been removed and replaced with level-access showers. These are easier to use when patients are recovering from orthopaedic surgery.

The high dependency unit had recently been renovated and the capacity increased from two to three beds. Again, this renovation had been completed to a high standard. A new nursing station had also been created and the shower room had been upgraded to include level-access showers.

The renovations of Beechwood House and consulting rooms in the main hospital were now complete. This work had created very good facilities for outpatient consultations, examinations and treatments.

The theatre suite had four operating theatres. Two of them had laminar flow ventilation and were used for higher risk operations, such as knee and hip replacements. One of the four theatres was very large, set off the main corridor and had its own dedicated recovery area. This was often used for complex cosmetic procedures. The dedicated recovery area gave patients additional privacy. It was also useful for the changeover of theatre staff. The theatre suite also had its own sterile supplies department, which reprocessed the reusable equipment used in the hospital.
The general layout of the hospital supported the safe delivery of care. The flow of patients, equipment and waste in the theatre suite was appropriate and followed the principles of ‘clean to dirty’. The patient bedrooms, consulting rooms and treatment rooms were all provided with facilities and equipment to support the implementation of the standard infection control precautions. These are 10 key precautions staff should take to minimise the spread of infection. They include hand hygiene, the use of personal protective equipment (aprons and gloves), and the management of linen, waste and sharps.

The standard of housekeeping in the hospital was very high. All areas we inspected were clean. The housekeeping cleaning records were comprehensive and included all the cleaning duties completed every day, as well as spot checks carried out by the team leader.

Area for improvement

While we saw that work had been done to improve the patient equipment cleaning schedules for clinical staff, they were still not being completed reliably. A system had yet to be developed to review the completion of the new documentation. A simple system of weekly sign-off by the ward sister, with feedback to the nursing services manager by email on performance in this area, may be sufficient. It was also clear from the records that cleaning was only carried out on certain days. The details in the cleaning schedule should be further reviewed. The schedules should reflect the actual cleaning required, in particular the frequency. Cleaning tasks could then be distributed across different days and shifts so these important tasks are less burdensome (see recommendation b).

- No requirements.

Recommendation b

- We recommend that the service should develop a simple system of monitoring and feedback to ensure that the records of patient equipment cleaning undertaken by nurses and healthcare assistants are kept up to date.

Quality Statement 2.3

We ensure that all our clinical and non-clinical equipment within our service is regularly checked and maintained.

Grade awarded for this statement: 5 - Very good

The service had comprehensive arrangements to ensure that all equipment was maintained and regularly checked. The provider had contracted a number of organisations to provide planned preventative maintenance of all the clinical and non-clinical equipment.

We saw that the fire alarm system was last serviced in July 2015. There was also evidence that the company responded rapidly when called out. The service was also able to demonstrate that the regular checks they were responsible for were carried out, such as weekly alarm sounder tests.

The water system was inspected and risk assessed every year. We were shown evidence of the last risk assessment carried out in February 2015.

A company was employed to maintain and validate the theatre ventilation system. The paperwork we reviewed stated that the system was satisfactory. However, the report identified a number of improvements that the system required. We saw that the service was working on the recommended upgrades, such as fitting inspection windows to the duct work.
The service had an electronic system to help it manage the regular maintenance checks that had to be carried out. We were shown how the system allocated tasks to the hospital engineers as they were due. The engineers then completed the tasks and marked them as complete on the system. We were able to see that this allowed the service to evidence that these tasks were completed.

Each ward also had a maintenance book. This was used to communicate minor repairs from the ward to the engineering team. We saw that this was effective and that some minor repairs we noted had already been identified in the log book and were waiting for action to be taken.

- No requirements.
- No recommendations.

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

The service had very good systems for staff recruitment, including a recruitment and retention policy. Posts were advertised through a variety of internet websites, including the corporate website and using local press. Applicants submitted an application form and were interviewed by two senior staff using a set of questions based on the role requirements. Each role had a job description.

We reviewed five staff files, which contained:

- an application form and/or curriculum vitae
- interview questions and responses
- an occupational health questionnaire
- two references
- professional registration information from the Nursing and Midwifery Council, and
- a Protecting Vulnerable Groups (PVG) Disclosure Scotland reference number.

All staff completed a comprehensive induction, which included:

- any role-specific mandatory training
- compassion in practice
- equality and diversity
- fire safety
- health and safety
- manual handling, and
- safeguarding vulnerable adults.
A new starter induction checklist was completed by staff supported by a ‘buddy’. A buddy is an experienced staff member who is designated to support newly-appointed staff. The checklist helped to make sure all necessary related work information was provided to the new employee.

We interviewed a range of staff who told us the induction was ‘excellent’. They all felt supported by their buddy.

Medical staff who applied to work at the hospital were interviewed by the chair of the medical advisory committee and a specialist in their field. We saw that there was a robust medical recruitment process. All relevant checks including references, registration with the General Medical Council and PVG checks were undertaken.

Areas for improvement

Heads of departments were responsible for their staff files. We looked at five staff files and noted that the contents were not organised in a consistent way. The human resource manager told us that staff files would be standardised and filed in an agreed order (see recommendation c).

Candidate responses to questions asked at interview should be graded in line with Spire Healthcare Ltd’s recruitment and selection policy. In the staff files we looked at, gradings had not been allocated. There was also no record of discussion of the quality of candidate or decision reached about their appointment (see recommendation d).

- No requirements.

Recommendation c

- We recommend that the service should standardise staff files to ensure all recruitment checks have been carried out to an agreed standard.

Recommendation d

- We recommend that the service should follow Spire Healthcare Ltd’s recruitment and selection policy to ensure a consistent approach.

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

Registrations for nurses and allied health professions, such as physiotherapists and occupational therapists, were checked and recorded using online verification systems. A system was in place to check registrations every month to ensure all were current.

The management support and compliance manager was responsible for managing consultants’ practising privileges. Practising privileges means a person managing a hospital can grant permission to a doctor to practise as a medical practitioner in that hospital. A new electronic system for consultants’ registration had been introduced. We saw medical staff details on the system included curriculum vitae, indemnity insurance, appraisal, PVG and registration with the General Medical Council. All doctors had to carry out a revalidation process every year to maintain their registration with the General Medical Council.
Consultants work primarily with the NHS and have revalidation arrangements in place with the NHS board Responsible Officer.

We spoke with seven patients during the inspection. Most patients told us that the quality of staff was excellent, and all said that staff were mindful of their privacy and dignity. One patient told us how considerate staff were to their family when visiting.

We also spoke with staff to find out their views of working in the hospital. Staff told us that Spire Murrayfield Hospital was a very good place to work. Staff told us they felt part of a team and were valued as staff members.

We looked at staff training information. We saw there was a range of both mandatory and elective training opportunities for staff, dependent on their role. These included:

- laser treatment
- medical gas training
- radiation protection training
- information governance
- infection control, and
- resuscitation.

Spire Healthcare Ltd had very good systems to support staff training and development. This programme was called ‘Enabling Excellence’ and ensured that staff had ongoing feedback about their performance. It also ensured that staff had opportunities to develop their skills. The main elements of the programme were performance reviews, performance planning, coaching and feedback.

Spire Healthcare Ltd’s online training programme was called ‘Access Academy’. Staff had a list of training requirements relevant to their role that they must complete every year. Staff also carried out a range of competencies such as intravenous (IV) infusion management and injectable medication.

In preparation for nursing revalidation, the hospital had developed a nursing portfolio. This included records of reflective practice, training and education, and clinical supervision. We saw that staff received very good information about the service, developments and clinical practice through noticeboards, meetings, huddles and email.

**Area for improvement**

The self-assessment identified that work was ongoing to improve staff understanding of the National Care Standards for Independent Hospitals (2005).

- No requirements.
- No recommendations.
Quality Theme 4 – Quality of management and leadership

Quality Statement 4.2
We involve our workforce in determining the direction and future objectives of the service.

Grade awarded for this statement: 5 - Very good

The Spire Murrayfield Hospital 2015 plan set out the objectives for the service. Various forums were used to involve staff in creating and commenting on this plan. Team leaders had regular off-site meetings with the hospital director to discuss and contribute to the plan. Regular staff updates were given with an open forum for questions and answers.

The structure of staff meetings meant that different staff groups could meet to discuss aspects of the plan. The senior management team’s weekly meeting considered the plan. Heads of department held a meeting every month. We looked at minutes of these meetings and saw they were held regularly.

Senior nurses had a regular informal meeting. This was used to discuss issues and support one another. This had been in place for over 18 months and was felt to be helpful for mutual support. Each staff member had objectives set which were in keeping with the overall hospital plan.

A staff survey was carried out in 2014. This showed some staff disagreed with the pay scale at the hospital, which had led to a review of the pay scale. Following the review, the service’s staff were paid in line with NHS staff. This meant some staff were given pay rises and improved terms and conditions. This example demonstrated that management had listened and responded to a staff concern.

Staff we spoke with felt they could contribute to the development and improvement of the hospital. They felt encouraged that management listened and responded to their comments.

The service also took the opportunity to seek the views of the consultants with practising privileges at the hospital and the GPs who referred patients to the hospital. The 2014 consultant survey showed that their general satisfaction with the service had improved since 2013. The service also responded to requests from consultants. We saw evidence of new patient information that had been developed at the request of a consultant. An action plan had been developed as a result of the 2014 GP survey. This showed that the service took comments seriously from this group of stakeholders.

■ 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

Before the inspection, the service submitted a comprehensive self-assessment to Healthcare Improvement Scotland. The service completes this self-assessment each year. It gives a
measure of how the service has assessed itself against the quality themes and National Care Standards. We found very good quality information in Spire Murrayfield Hospital’s self-assessment that we verified during our inspection.

The service had very good, robust quality assurance systems. The clinical governance structure comprised the following committees:

- medical advisory
- clinical effectiveness
- clinical governance, and
- senior management team.

A range of other groups also reported into the clinical governance structure. These included health and safety, infection control and team meetings.

The medical advisory committee held overall responsibility for clinical governance at the hospital. Membership included the hospital director, head of clinical services and consultants.

The hospital used a range of methods to measure the quality of the service. These included:

- surveys and questionnaires
- audits
- complaints and feedback
- clinical scorecard, and
- accidents and incidents.

We looked at minutes from the clinical effectiveness committee. We saw that these included discussion on:

- adverse clinical events
- infection control
- audits
- the clinical scorecard
- root cause analysis
- risks
- health and safety, and
- corporate updates.

Spire Healthcare Ltd’s corporate clinical governance group had developed a clinical scorecard system in line with the Care Quality Commission’s reporting system. The scorecard comprised a number of key indicators used to measure service delivery, such as falls, complaints, pressure ulcers and infections. Reports were submitted to head office and services were benchmarked against each other to measure performance.

There was a clear procedure for patients to make complaints. A spreadsheet was used to log complaints and the outcomes. These were then reported through the clinical governance structure.
An internal and corporate-led audit programme was in place, which covered all aspects of service delivery. We saw that results of audits were reported through the clinical governance structure. Action plans were developed in response to any gaps identified.

**Area for improvement**

The matron discussed future plans to involve staff from all levels in clinical governance processes and in promoting a culture of continuous improvement.

- 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 1.1

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
</tr>
</thead>
</table>

**Recommendation**

**We recommend that the service should:**

- a build on the marketing department’s outline work plan and develop a formal document that sets out planned participation activity, the expected outcomes and a measure for effectiveness (see page 13).

  National Care Standards – Independent Hospitals (Standard 9 - Expressing your views)

  A similar recommendation was previously identified in the August 2014 inspection report for Spire Murrayfield Hospital.

### Quality Statement 2.2

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
</tr>
</thead>
</table>

**Recommendation**

**We recommend that the service should:**

- b develop a simple system of monitoring and feedback to ensure that the records of patient equipment cleaning undertaken by nurses and healthcare assistants are kept up to date (see page 16).

  National Care Standards – Independent Hospitals (Standard 13.1 - Prevention of infection

  A similar recommendation was previously identified in the August 2014 inspection report for Spire Murrayfield Hospital.
<table>
<thead>
<tr>
<th>Quality Statement 3.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td><strong>c</strong> standardise staff files to ensure all recruitment checks have been carried out to an agreed standard (see page 18).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 10 – Staff)</td>
</tr>
<tr>
<td><strong>d</strong> follow Spire Healthcare Ltd’s recruitment and selection policy to ensure a consistent approach (see page 18).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 10 – Staff)</td>
</tr>
</tbody>
</table>
### 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>23/10/2013</td>
<td>5 - Very good</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>Not assessed</td>
<td>5 - Very good</td>
</tr>
<tr>
<td>19–20/08/2014</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>5 - Very good</td>
<td>5 - Very good</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: comments.his@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:
Appendix 5 – 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 6 – Details of inspection

The inspection to Spire Murrayfield Hospital, Spire Healthcare Ltd, was conducted on Wednesday 12 and Thursday 13 August 2015.

The inspection team was made up of the following members:

Kevin Freeman-Ferguson
Senior Inspector

Karen Malloch
Inspector

Stella MacPherson
Public Partner

Observed by:

Tammy Fenton
Project Officer
Appendix 7 – Terms we use in this report

<table>
<thead>
<tr>
<th>Terms and explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>provider</strong></td>
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<tr>
<td><strong>service</strong></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.

**Edinburgh Office**
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Phone: 0131 623 4300

**Glasgow Office**
Delta House
50 West Nile Street
Glasgow
G1 2NP

Phone: 0141 225 6999

**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.