Unannounced Inspection Report: Independent Healthcare

The Priory Hospital Glasgow | Priory Healthcare Limited
29 February – 1 March 2016
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1 A summary of our inspection

About the service we inspected

The Priory Hospital Glasgow is a private psychiatric hospital registered to provide nursing care for up to 42 inpatients and up to 40 day patients. The hospital has two units: a facility for women with an eating disorder and a second unit for adults with a range of general mental health disorders including substance misuse. The hospital offers a range of therapeutic programmes for patients.

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 The Priory Hospital - Glasgow on Monday 29 February and Tuesday 1 March 2016.

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 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:** 4 - 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 The Priority Hospital – Glasgow 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
- the self assessment
- any notifications of significant events, and
- the previous inspection report of 10 and 11 June 2014.

During the inspection, we gathered information from a variety of sources. This included:
• audits
• consent forms
• the incident log
• maintenance records
• medication administration sheets
• minutes from meetings
• monthly summary reports
• patient care records
• policies and procedures
• staff files, and
• training records.

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

• five patients
• the auditor
• charge nurses
• the clinical services manager
• a dietitian
• the head housekeeper
• healthcare support workers
• housekeeping staff
• the maintenance manager
• a psychiatrist
• a psychology student
• a senior healthcare support worker
• staff nurses
• the registered manager
• therapists, and
• ward managers.

We visited the following areas:

• bedrooms
• lounges
• therapy rooms
• main dining area
• medication/treatment room, and
• external areas.
What the service did well
The service provided a safe supportive environment for its patients. There was an extensive therapeutic programme in place and care was provided by a robust multi-disciplinary team approach. We found that staff were enthusiastic and engaged with the patients. The feedback from patients about the care they received was positive and there was clear evidence of patients’ involvement in planning their care and reviewing progress. Regular patient forums and a patient representative supported patients to have their say about the service and to make suggestions for improvement and we saw that these were followed through. The overall management framework showed that there was a very good system in place to monitor all aspects of the service.

What the service could do better
The service should review its care plans and ensure a consistency of quality. Care plan intervention and outcomes should be specific and measurable. Staff providing direct care should receive specific training in eating disorders as planned. Some work is required to educate staff further on the Mental Health (Care and treatment) (Scotland) Act 2003. In particular, for cross-border patient transfers.

This inspection resulted in no requirements and eight recommendations. See Appendix 1 for a full list of the recommendations.

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

What the service had done to meet the recommendations we made at our last inspection on 10 and 11 June 2014

Recommendation

*We recommend that the service should ensure that patients undergoing detoxification are regularly assessed using a recognised withdrawal rating scale.*

**Action taken**

The service has now implemented a validated assessment tool (clinical institute withdrawal scale for alcohol) and we saw this was being used as part of the assessment process. **This recommendation is met.**

Recommendation

*We recommend that the service should ensure that all staff who administer medication have their practice observed periodically to ensure that they are administering the medication safely.*

**Action taken**

The service had established a medication framework that included observation and verification of practice. We saw that all staff except one had completed this competency will be an annual exercise. **This recommendation is met.**

Recommendation

*We recommend that the service should ensure that all clinical equipment in the service is regularly checked and calibrated to ensure that they are giving an accurate reading.*

**Action taken**

We have amended this recommendation. Please see recommendation h and is reported under Quality Statement 2.3.
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 hospital had a website that provided details about each service. The website included a virtual tour of the facility and there were a variety of leaflets that are available to read and download. The website also provides short video clips made by former patients about their experience in using the service. Management told us that the website is due to be updated and the format will be improved. A corporate pack ‘Helping you to get the most from your treatment at the Priory’ also provides information about the range of services the provider has, including contact information and treatment programmes.

Locally patients were given a patient pre admission information booklet on or before admission. This booklet provided information about the hospital services, including:

- what to bring when being admitted
- the environment and facilities available
- confidentiality
- patients’ legal rights
- how to complain, and
- the treatment programme.

Dedicated staff responded to telephone and online enquiries and provided a range of information, including treatment and therapies available and costs of treatment. Prospective customers were encouraged where possible, to visit the service, look round and ask questions. A large number of patients are transferred from England and Ireland to receive treatment and information about the service is sent to the commissioning teams in other areas so they can decide if the service is the right one for the person they are referring.

A weekly patients’ forum meeting helped give patients information and updates about programmes and events.

A member of staff was developing an information leaflet for family and carers to provide helpful information on the patient’s illness and treatment.

Area for improvement

The majority of patients were from England or Ireland through cross-border transfer arrangements. Some patients told us that they would have liked to have received more information about the service prior to transfer. The service should review how information is provided to patients who are transferred from other regions and how this could be improved. The manager told us that service information was provided to commissioning teams and they relied on the teams to pass this information on to the patient (see recommendation a).
No requirements.

Recommendation a

We recommend that the service should review how information is provided to patients admitted through cross-border transfer arrangements and look at ways to improve this.

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

On admission to the service, patients were required to sign a range of consent forms. These included consent to:

- treatment which the patient signed following explanation by the doctor about the course of treatment and any likely side effects.
- what information the service shares with the patient’s GP, and
- whom in their family and friends they would like information shared with, if any.

The consent forms were audited monthly and reviewed by clinical governance staff and we saw that all of these were completed appropriately and signed by patients.

A ‘conditions of admission’ form detailed conditions of stay and covered a range of areas such as valuables, self-medication, mobile phones, leave, confidentiality and behaviour expectations. Patients were asked to read and confirm their understanding of these rules and possible penalties if these were breached.

Care and treatment plans were developed in partnership with each patient. We looked at five patient care records and these showed that patients had signed and agreed their plan of care. During our inspection, we were accompanied by a public partner who spoke with five patients, who were able to tell us that they had signed and consented to treatment.

Many patients who were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 are cross-border transfers and this is a complex process in relation to consent and ensuring the correct paperwork is completed and signed. A member of staff was responsible for the Mental Health Act’s administration and had a comprehensive tracker in place that covers all aspects of each patient’s individual requirements are recorded including tribunals and reviews. We looked at paperwork in relation to treatment in respect of the Acts and saw this was completed.

Area for improvement

There have been previous problems in ensuring correct mental health consent paperwork in relation to medication was in place. Management told us that weekly meetings had been convened to ensure all aspects of patient care, including mental health were discussed and actioned. Nursing staff had limited knowledge about the implications, process and paperwork required when transferring a detained patient in to Scotland. Education for the whole staff team would promote understanding (see recommendation b).
No requirements.

**Recommendation b**

- We recommend that the service should provide education for staff on the mental health legislation in place in the UK and the Republic of Ireland, specifically in relation to cross-border transfer arrangements and requirements for patients detained under mental health legislation.

**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**

We saw that the service used a number of different methods to ensure patients and their carers participated in evaluating the services provided.

Both wards held an inpatient forum every fortnight. A former patient chairs one of the meetings and attends the other as an observer. This person also attends clinical governance meetings to ensure patients’ views are represented. Minutes of the forums were displayed on the ward noticeboards. The ward manager replies to the issues raised and these are also placed on the ward noticeboards to keep patients up to date with progress.

Pre-admission information was available that told people how they can be involved in expressing their views, either through questionnaires or complaints. People can also access the advocacy service if they need help to give their views.

Family members should be included as much as possible in the treatment of eating disorders. New information booklets were being produced for staff, patients and carers. We spoke to a university student on placement who was taking this forward. They explained how the different groups had been involved in the selection of material for the new booklets and that the booklets would now be going out to the various groups for comment. We saw the feedback forms which will be used for this process. Questions included:

- Do you think the design of the leaflet is appropriate?
- Is there any information that could be added to the leaflet?
- Is there any content that you think should not be in the leaflet?
- Do you think this leaflet would be helpful for a new admission into the ward?

All patients were involved with planning and developing their care and treatment through attending the multi-disciplinary team meetings. For these patients, it is essential they are fully involved and committed to their care and treatment to ensure good outcomes.

The ward manager told us that patients from the eating disorders unit were routinely involved in staff interviews and explained the process. A patient told us:

’I liked being involved in interviews. I could ask them questions from a patient’s point of view, it was a good experience.’
This is a good example of promoting patient involvement in the recruitment and selection of staff.

All patients are encouraged to complete a questionnaire on discharge. This covers a wide range of issues about the patient’s experience of using the hospital, including staff attitudes, medication, food and the environment.

A patient told us: ‘The community meeting works very well and the report is up on the wall to look at.’

Areas for improvement

The service did not have a formal participation strategy setting out a planned approach on how to obtain feedback from patients and how to respond to it. The development of a formal strategy could outline this activity clearly and benchmark expectations so that it can be measured for effectiveness (see recommendation c).

We saw there were very positive results from the patient satisfaction survey with 97% of patients stating they were happy with their care. We suggested that this information could be displayed to give feedback to patients, staff and carers. We were told this information is normally displayed, but due to redecoration it had been taken down. We will follow this up at future inspections.

■ No requirements.

Recommendation c

■ We recommend that the service should develop a formal patient and relative’s participation strategy.

Quality Statement 1.5

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

Grade awarded for this statement: 4 - Good

We looked at six patient care records. The service used a web-based electronic patient record system called ‘Carenotes’. Assessments, care plans, risk assessments, reviews and progress notes were on the system and all members of the multi-disciplinary team recorded patient information and their progress. The admission pack, including patient consent forms, admission checklist, property and medication reconciliation were on separate paper documents. Care plans were printed and signed by patients.

All patients were assessed on admission by a doctor and then by a nurse. We saw that a basic health screening was undertaken and included consideration of cardiac disease, blood pressure and diabetes. Physical observations were taken at the time of admission and these included weight and body mass index. This is particularly important in an eating disorders unit where physical health can be severely compromised. Specialised focused assessments are conducted by dietitian and other members of the multi-disciplinary team dependent on...
patient need. We saw that the assessment process took into consideration patients physical, psychological, emotional and spiritual needs.

A risk assessment is carried out by the doctor as part of the initial assessment and the outcome of this informs the level of observations the patient will be subject to. Risk assessments are reviewed weekly at the multi-disciplinary team meeting and in response to any incidents or concerns.

We found the record system was relatively easy to negotiate which included alerts on mental health status. Observations and allergies were also highlighted. The progress notes contained a minimum of two daily entries and we found a good standard of recording. We saw examples of care plans, that included problems and goals being phrased in the patient’s own terms and we were told that staff were encouraged to be more person-centred when developing plans. We saw that regular reviews of individual care needs were carried out by a multidisciplinary team and patients were given the opportunity to attend and be involved in their care reviews. Patients we spoke with confirmed they felt part of their care.

We spoke with a number of staff and found them to be knowledgeable about their patients. Staff told us the daily handover meeting gave them an opportunity to catch up on patients progress, discuss any incidents and ensure that they were aware the patients risk status.

We saw that the patient care co-ordinator had established good communication with commissioning teams and ensures that they receive a weekly copy of the multidisciplinary team notes, and a monthly summary of their patient’s progress. Regular video case conferences also took place to discuss the patient’s progress and discharge planning.

**Areas for improvement**

We looked at assessments and saw that some physical assessments conducted by junior doctors had not been fully completed. We found that some baseline observations had not been recorded and, in a couple of instances, the section on ongoing medical problems was left blank (see recommendation d).

Although care plans were in place, the standards varied across the service. We did see some detailed care plans; but many were not specific, measurable or timed and lacked clear clinical directions. We noted that the weekly local care plan audit is not carried out by a clinician and, therefore, clinical interventions are not considered as part of the audit (see recommendation e).

We found the risk assessment to be basic and the assessment often contained no detail about the specific risks. Supplementary information would be useful to inform what the specific risks and triggers are without having to refer to other assessment documentation (see recommendation f and g).

- No requirements.

**Recommendation d**

- We recommend that the service should implement a system to ensure that physical assessments carried out by junior doctors are fully completed.
Recommendation e

We recommend that the service should review the quality of care plans to ensure inclusion of clinical interventions and measurable goals.

Recommendation f

We recommend the service review the current local care plan audit to ensure inclusion of clinical content.

Recommendation g

We recommend that the service should review current use of the risk assessment tool to include the specific detail of the actual risks.

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 was provided in two large converted houses, one of which had been extended and provided the majority of patient accommodation. The service had access and facilities for people affected by mobility problems. The grounds were accessible and well maintained, with a designated smoking area for patients. The building had secure access and visitors were required to sign in and out.

We looked at a sample of patient bedrooms, therapy rooms, patient lounges, the main dining room, the pharmacy and ward pantries. All areas we saw were well maintained and clean, with comfortable furnishings. The design and layout of the service was spacious and inviting and there were a number of pleasant, quiet rooms for people who use the service and their visitors to use. All bedrooms were single and had en-suite facilities. Three bedrooms were 'ligature proof'. These rooms are specifically designed without ligature or anchor points to reduce the possibility of a patient harming themselves. We saw that each room had an extensive ligature risk assessment undertaken and controls in place to manage risk highlighted.

We saw that a fire risk assessment had been carried out in April 2015, and an action plan developed. Staff had regular fire training and fire marshalls’ were also identified in each of the ward areas. Four practice evacuations were carried out every year. Fire notices were displayed which showed people directions to the nearest evacuation point.

We saw from the minutes that health and safety meetings were held regularly and these were reported at the clinical governance meetings. Environmental risk assessments, including water risk assessments were in place. The annual health and safety audit was due, and we noted from the last audit that the housekeeping team had been commended. An annual infection control audit was also carried out and an action plan developed.

We saw that room and fridge temperatures were checked and recorded.

The service was undergoing refurbishment and many areas had recently been painted and new furnishings purchased.
Patients we spoke with commented that they found the environment comfortable and pleasant. Patients were encouraged to bring personal possessions to provide a sense of familiarity and we saw many examples of personalised rooms.

**Area of improvement**

As the service is provided in older buildings, ongoing maintenance and repair work was always required. During our inspection, the water tanks were being cleaned and this had resulted in water coming from an overflow and some disruption to the water supply. We noted from patient concerns raised at the patient forum and from patients we spoke with that there had been issues with heating and water in the past. These issues had now been resolved with patients being compensated. The service should continue to ensure that patients are kept fully informed about building and maintenance issues that may affect them.

- No requirements.
- No recommendations.

**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**

We found that the service had systems to manage servicing and maintenance of clinical and non-clinical equipment. We spoke with the maintenance manager who showed us service records for equipment, both clinical and non-clinical, including equipment serviced by outside contractors. They were also able to show us the process for reporting and recording issues with equipment, and how that was dealt with on a daily basis by staff reporting issues in folders within their areas. The maintenance manager was able to show us how these were recorded in the electronic maintenance management system. This system then generated work orders and maintenance requests. We were able to track a reported maintenance issue from start to completion. All staff we spoke with knew how to report issues with equipment and patients were also given this information.

We carried out spot checks on a sample of equipment, including:

- the lift
- the boiler, and
- a blood glucose monitor.

We viewed the service records and the routine checks carried out. We saw that equipment was serviced and maintained. We also saw that the nurse call bells were checked regularly to ensure that they were in good order. Portable appliance testing was carried out by an external company.

**Area for improvement**

Although we saw that clinical equipment is being checked regularly, calibrated every year or replaced, we saw the blood glucose monitor was for single patient home use and not for multiple patient use by healthcare staff. The hospital should ensure that the blood glucose monitor is fit for the purpose it is being used (see recommendation h).
Recommendation h

We recommend that the service should ensure clinical equipment is suitable for the purpose it is being used.

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: 6 - Excellent

We saw that policies and procedures were in place to support safe recruitment in the service. We were told that the administration processes for recruitment were now managed centrally in the organisation.

We looked at four recruitment files chosen at random. The files were in good order and easy to follow. All the files we looked at included:

- role descriptions
- a health declaration
- a note of the Protecting Vulnerable Groups (PVG) Scheme, or Disclosure Scotland reference number
- registration checks for professional bodies
- details of experience and skills, and
- two references.

A member of staff explained to us the system and process for granting a doctor practising privileges at the service. Practising privileges is the process a medical doctor goes through to get permission to practise as a doctor at a hospital. We looked at the files of a consultant who had recently been given practising privileges in the service. We saw that the doctor had submitted:

- a self-declaration of fitness to practise
- evidence of registration with the General Medical Council
- up-to-date insurance
- an application form
- two references
- evidence of past experience, and
- evidence of up-to-date appraisal and revalidation.

We also saw that individual applications were discussed at the medical advisory committee meeting.
An induction programme was in place within the service. The induction programme included time for online and face-to-face learning. It also included a period when new staff worked on a supernumerary basis. This means they are able to work without being counted in the normal number of staff who would cover the shift. This allows them to work closely with experienced colleagues and learn about how the service runs. All staff spoke positively about the induction process. They told us they felt the induction process had prepared them for the role they were asked to perform.

- No requirements.
- No recommendations.

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
The service had access to the corporate computer-based training system called ‘Foundations for Growth’. This system set out all the mandatory training for employees based on their role in the service and involves elements of online and face-to-face training. Mandatory training for all staff included:

- adult basic life support
- fire safety
- health and safety
- infection prevention and control
- safeguarding
- moving and handling, and
- The Equality Act (2010).

Other courses are role specific and include:

- safe handling of medicines
- crisis management, and
- food safety for food handlers.

The system also monitored when a particular module was last completed and reminded staff and managers when refresher training was due. The electronic system provided management staff with an annual overview of completed training and training due. This is a useful tool to help make sure all staff complete the training required within the timeframes. This was being monitored at both a corporate and local level.

Face-to-face training also took place to supplement online training and some staff acted as links or champions for specific areas such as infection control.

Annual appraisals were carried out to monitor staff performance and plan for professional development. Most staff still used hard copy appraisal documentation, but the service was planning to roll out the online appraisal system provided by Priory Healthcare Limited. The
service had a system of one-to-one clinical supervision in place every 4 - 6 weeks. The therapists also had a peer support supervision and nursing staff took part in debriefs after any incident.

A designated member of staff was responsible for ensuring that consultants had a performance review every 2 years. We noted that a check was carried out every month to ensure that staff were registered with their professional body.

Each department had a communication diary where staff could record important information and this helped communication between the different shifts. The service was about to carry out its clinical staff survey after our inspection.

During the inspection, staff spoke positively about working in the service. They felt they were well supported and that people worked well together across the different teams. All staff we spoke with described an open, approachable management team, a feeling of being able to voice opinions and be listened to, and a team approach. Staff were all aware of the whistle blowing policy and spoke of being comfortable to raise concerns, should they have any.

Areas for improvement
The service had increased the amount of patients in the eating disorders unit. These patients had complex needs and many staff felt specific training was required to deal with this. The ward manager had completed a training for trainers course in this subject and was planning to carry out training for staff. The service should ensure that specific training is given to staff for dealing with patients with an eating disorder (see recommendation h).

During our inspection, we saw that the ward areas did not have staff meetings. Although other groups of staff did, such as therapists. This was due to shift work and ensuring staff could attend if the ward was busy. Each ward had a patient handover in the morning and other issues were also discussed at that time. The service could look to capture this information and communicate to all other nursing staff.

- No requirements.

Recommendation i
- We recommend that the service should ensure that specific training is given to staff for dealing with patients with an eating disorder.

Quality Theme 4 – Quality of management and leadership

Quality Statement 4.2

Grade awarded for this statement: 5 - Very good
Systems were in place to promote staff involvement in service development and service objectives. The clinical governance meetings had staff representation from nursing and therapy staff.

The chief executive officer of the organisation regularly phoned into the service on a conference call and all staff were invited to receive an update on any organisational developments and ask any questions or make comments.
We saw a monthly staff corporate newsletter that provided staff with information, progress and initiatives from the organisation. Locally staff were encouraged to contribute, but the uptake had been poor.

Staff annual appraisal objectives were developed in line with the services overall strategic objectives.

To promote the healthcare assistant’s voice in service progression, senior healthcare assistants had been appointed. Plans were in place to establish regular meetings with healthcare assistants to provide support and an opportunity to gather feedback and views.

Staff we spoke with told us they felt involved in influencing the future direction of the service at a local level. Staff felt comfortable to express their opinions and told us they felt listened to. The service had various methods for supporting staff including appraisal, supervision and through de-brief sessions following incidents. Suggestion boxes were also available for staff to use.

The organisation roadshow was planned for 15 March 2016, led by the group medical director. This was open to all staff and will provide information to staff on developments, and activities. Some staff told us that they did not have a sense of being involved in the greater corporate identity. However, management told us the roadshow would provide an opportunity to promote that inclusion for staff.

A staff survey was due to be disseminated to staff. Management told us the results would be used to identify areas to improve staff management and staff participation in service development.

**Area for improvement**

Management recently organised a staff form which took place every 3 months, but attendance was poor. The management team could look at other ways to meet and engage with staff.

- No requirements.
- No recommendations.

**Quality Statement 4.4**

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

**Grade awarded for this statement: 5 - Very good**

The service submitted a basic self-assessment to Healthcare Improvement Scotland. 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. We found the quality information to be adequate, but we were able to verify it during our inspection.

The organisation had very good systems and processes in place to assess the quality of the service. We saw that the quality assurance programme included a range of meetings:

- audit committee
• clinical governance
• corporate clinical governance
• medical advisory committee, and
• multi-disciplinary meetings.

We saw that these meetings were used to discuss and analyse a range of information and data used to monitor how the service was performing, and included:

• accident and incidents recording
• audits
• complaints
• patient forums, and
• patient and staff surveys.

The head of departments attended the monthly clinical governance meeting. A standing agenda covered all aspects of quality assurance activities. A patient representative was also invited to attend. We looked at the minutes and saw that they contained clear action plans, including timescales and responsibility, and we saw that these were tracked and followed through.

A dedicated member of staff managed the local auditing programme and developed action plans for the gaps identified. We saw a local and a corporate audit plan in place. An audit committee met monthly to discuss audits, action plans and progress. We saw good evidence of audit results leading to improvements in processes, for example doctors were now required to complete discharge risk assessments following gaps identified in an audit.

There was a monthly corporate clinical governance meeting and representatives from the provider’s other services attended. Each service submitted a range of quality performance indicators, including audits, complaints, accidents and incidents. Services were benchmarked against each other and action was required if results were outwith the acceptable range.

The service achieved the ‘Best Hospital in The Priory Group’ in 2015 and had been awarded the Healthy Living award for the past 4 years.

Area for improvement
We found staff awareness of the outcomes of audits varied. The service could consider how to ensure staff receive information about outcomes of quality assurance activities.

■ 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.

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<tr>
<td>d</td>
<td>implement a system to ensure that physical assessments carried out by junior doctors are fully completed (see page 12).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)</td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>review the quality of care plans to ensure inclusion of clinical interventions and measurable goals (see page 13).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)</td>
<td></td>
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<tr>
<td>f</td>
<td>review the current local care plan audit to ensure inclusion of clinical content (see page 13).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>review current use of the risk assessment tool to include the specific detail of the actual risks (see page 13).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 12 – Clinical effectiveness)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Statement 2.3</th>
<th>Requirement</th>
<th>None</th>
</tr>
</thead>
</table>
**Recommendation**  
We recommend that the service should:

<table>
<thead>
<tr>
<th>h</th>
<th>ensure clinical equipment is suitable for the purpose it is being used (see page 15).</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 5.5 – Your environment)</td>
</tr>
</tbody>
</table>

### Quality Statement 3.3

<table>
<thead>
<tr>
<th>Requirement</th>
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<tbody>
<tr>
<td>None</td>
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</table>

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

<table>
<thead>
<tr>
<th>i</th>
<th>ensure that specific training is given to staff for dealing with patients with an eating disorder (see page 17).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Care Standards – Independent Hospitals (Standard 10.10 – 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>03 - 04/12/2012</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
</tr>
<tr>
<td>10 - 11/06/2014</td>
<td>6 - Excellent</td>
<td>5 - Very good</td>
<td>5 - Very good</td>
<td>6 - Excellent</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](mailto: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: [http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_healthcare.aspx](http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_healthcare.aspx)
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 The Priory Hospital Glasgow, Priory Healthcare Limited was conducted on Monday 29 February and Tuesday 1 March 2016.

The inspection team was made up of the following members:

Karen Malloch
Senior Inspector

Winifred McLure
Inspector

Stella McPherson
Public Partner
## Appendix 7 – Terms we use in this report

### Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
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<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.

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.