Unannounced Inspection Report: Independent Healthcare

Service: Ross Hall Hospital, Glasgow
Service Provider: BMI Healthcare Limited

16–17 December 2019 and 27 February 2020
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1   Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 11–12 April 2017

Recommendation
We recommend that the service should revise the consent form in line with Scottish legislation. The consent form should include a section to formally document the benefits and risks of treatments and procedures that are discussed with the patient.

Action taken
The patient care records we reviewed had completed consent forms that set out the risks and benefits of the proposed treatments. Consultants and patients signed these consent forms. This recommendation is met.

Recommendation
We recommend that the service should make sure that all staff consistently record the patient’s consent to share information.

Action taken
This is reported under Quality Indicator 5.2. This recommendation is not met (see recommendation f).

Recommendation
We recommend that the service should make sure that patient care records are fully completed and unused parts are removed or marked as not applicable.

Action taken
This is reported under Quality Indicator 5.2. This recommendation is not met (see requirement 3).

Recommendation
We recommend that the service should ensure compliance with Health Protection Scotland’s national infection prevention and control manual for the use of personal protective equipment. This will reduce the risk of cross-infection in the theatre department.

Action taken
This is reported under Quality Indicator 5.1. This recommendation is not met (see requirement 1).
Recommendation

We recommend that the service should improve the storage of items in the theatre department.

Action taken

The theatre department had a lack of storage space. However, store rooms were well organised and clutter free. This recommendation is met.

Recommendation

We recommend that the service should review the placement of patients before going into the operating theatre.

Action taken

This is reported under Quality Indicator 5.1. This recommendation is not met (see recommendation d).

Recommendation

We recommend that the service should develop a method of recording how clinical and day-to-day supervision is recorded.

Action taken

We saw evidence that a new system had been put in place to record clinical supervision. This recommendation is met.
2 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against three key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Ross Hall Hospital on Monday 16 and Tuesday 17 December 2019. We also returned to carry out a second unannounced inspection to the service on Friday 27 February 2020 as we had identified some immediate concerns to follow up. During our inspections, we spoke with members of staff and eight patients, as well as carers and family members.

The inspection team was made up of four inspectors, a clinical nurse specialist 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.

What we found and inspection grades awarded

For Ross Hall Hospital, the following grades have been applied to three key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
</tr>
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<tbody>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
<td>Patients said their care was high quality and staff treated them with dignity. The majority of patients were provided with information to allow them to make informed choices. Patient feedback was gathered and a process was in place to review complaints. Aftercare and support provided to patients with specialised cancers should be improved.</td>
<td>✔️ Good</td>
</tr>
</tbody>
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### Key quality indicators inspected (continued)

#### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tbody>
<tr>
<td>5.1 - Safe delivery of care</td>
<td>Safe systems were in place to manage medicines and staff followed World Health Organization guidelines for Safe Surgery. Staff were aware of their responsibilities in delivering safe care and had appropriate training. We saw some damaged patient equipment and contamination in the care environment. Infection prevention and control systems and processes must comply with national standards.</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

#### Domain 9 – Quality improvement-focused leadership

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4 - Leadership of improvement and change</td>
<td>Staff told us that leadership was visible and approachable. Staff had completed training to increase their knowledge of quality improvement methodologies to help drive change and improvement. Senior staff completed a leadership programme. Infection prevention and control quality assurance systems were not in line with best practice and must be improved. Audit programmes need more oversight from senior staff.</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

The following additional quality indicators were inspected against during this inspection.

### Additional quality indicators inspected (ungraded)

#### Domain 3 – Impact on staff

<table>
<thead>
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<th>Quality indicator</th>
<th>Summary findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 - The involvement of staff in the work of the organisation</td>
<td>Staff were positive about their work and their colleagues. They felt they had enough training to carry out their job and a system was in place to ensure regular appraisals were carried out. New nursing staff should be allocated a mentor and complete a role-specific induction package.</td>
</tr>
</tbody>
</table>
Additional quality indicators inspected (ungraded) (continued)

| Domain 5 – Delivery of safe, effective, compassionate and person-centred care |
|---|---|
| Quality indicator | Summary findings |
| 5.2 - Assessment and management of people experiencing care | The service had a records management policy and carried out monthly patient care record audits. Patients had a medical and nursing assessment carried out before treatment being undertaken. Patients care records must include a medical consultation and be fully completed. Patient risk assessments must inform a documented care plan. |

| Domain 7 – Workforce management and support |
|---|---|
| 7.3 - Communication and team working | We observed good patient handovers and multidisciplinary working. The service communicated information with its staff in a variety of ways. Regular ward staff meetings should be held. |

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.

More information about grading can be found on our website at: [http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx)

**What action we expect BMI Healthcare Limited to take after our inspection**

This inspection resulted in five requirements and eight recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: [www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx)

BMI Healthcare Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.
We would like to thank all staff at Ross Hall Hospital for their assistance during the inspection.
3 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people’s needs.

Domain 2 – Impact on people experiencing care, carers and families
High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People’s experience of care and the involvement of carers and families

Patients said their care was high quality and staff treated them with dignity. The majority of patients were provided with information to allow them to make informed choices. Patient feedback was gathered and a process was in place to review complaints. Aftercare and support provided to patients with specialised cancers should be improved.

Patients we spoke with described the quality of care and treatment received as ‘excellent’ and all patients we spoke with told us they had been treated with dignity and respect. For example:

- ‘They couldn’t do enough for me.’
- ‘The staff were very kind. Explained everything.’
- ‘They made it as comfortable and painless as possible. I was fully informed.’

Results and quotes from the service’s most recent yearly patient satisfaction survey were very positive and we saw them displayed in the reception area.

Information available to patients about the service through the provider’s website included descriptions and costs of treatments available. Senior staff also told us that the cost and payment options could be discussed when the patient first made contact. Enquiries could be made over the telephone or by email.

A good selection of patient information was available in the reception area. For example, information about consent and chaperone arrangements was available in different languages. Patients attending the service for surgery were
also given a personal information folder with treatment-specific information, including its risks, benefits and any alternatives.

Other leaflets in personal information folders included pain relief and advice about reducing the risk of blood clots. Patients we spoke with told us they had enough quality information about their treatments to allow them to make an informed choice. For example:

- ‘Told me everything I needed to know.’
- ‘ Loads of information.’
- ‘They answered everything.’

The service used a variety of methods to gather patient feedback, in line with its participation policy. This included different patient satisfaction questionnaires tailored for different departments of the service. An external company analysed questionnaires and produced a monthly report which we saw displayed in the inpatient areas.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when things go wrong. The service had a duty of candour policy and we saw the provider’s yearly duty of candour report.

The service had a complaints policy and we saw information displayed telling patients how they could make a complaint, including Healthcare Improvement Scotland’s contact details. The service was a member of the Independent Sector Complaints Adjudication Service (ISCAS). We reviewed two complaints and saw the service had dealt with them appropriately. Senior staff told us that the executive director and customer liaison officer met every week to discuss complaints.

**What needs to improve**
The service had good support in place for patients having chemotherapy, in particular those with breast and colorectal cancers. However, patients with some other cancers such as gynaecology had access to less or no specialised support, such as:

- a point of contact
- signposting, and
- the provision of written information to support their cancer diagnosis, pathway, treatment and follow-up (recommendation a).
The service’s website was not easy to navigate. For example, it was difficult to find where patients could leave feedback or find information about how to make a complaint. We will follow this up at future inspections.

While we saw positive feedback and survey results displayed in the service, details about how improvements had been made following complaints were not. This could help patients see how all their feedback is valuable.

- No requirements.

**Recommendation a**

- The service should review the information and support given to all patients’ post-cancer diagnosis. This will help to ensure that all patients are given the same level of specialised support to make informed choices. This should include a point of contact and appropriate aftercare and follow-up.

**Domain 3 – Impact on staff**

High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

### Our findings

**Quality indicator 3.1 - The involvement of staff in the work of the organisation**

Staff were positive about their work and their colleagues. They felt they had enough training to carry out their job and a system was in place to ensure regular appraisals were carried out. New nursing staff should be allocated a mentor and complete a role-specific induction package.

The most recent staff survey was completed in December 2018. Responses were positive about how interesting and fulfilling the jobs were, making good use of skills and staff said they felt trusted to do their job. An action plan had been developed to address issues identified in the survey, such as communication and recognising staff achievements. A staff engagement forum had been formed as part of the action plan and the service was carrying out a new staff survey at the time of our inspection.

We saw completed staff appraisals on the online appraisal system. Staff we spoke with stated that these helped with their career goals and helped them to feel valued. Staff said they received enough training to carry out their role. We saw evidence in staff files and training reports that staff completed mandatory
training. This included medical staff not employed directly by the provider but given permission to work in the service with practicing privileges.

Clinical staff had link nurse or ‘champion’ roles for different areas, such as cleanliness or pain management and were encouraged to take responsibility for promoting best practice and improvements in these areas.

In general, staff we spoke with were positive about the hospital and comments included:

- ‘Good place to work, nice people and good variety of work.’
- ‘All staff work well together including medical staff and all are very welcoming and supportive.’

**What needs to improve**
The service had an induction package in place for nursing staff. However, some of the service’s nursing staff who had started over the last 12 months had not been allocated mentors or given a role-specific induction package. They had raised this with senior staff and had recently been given mentors. However, at the time of inspection not all staff had received their role-specific induction package (recommendation b).

The service had not provided any information about this Quality Indicator in its submitted self-evaluation to Healthcare Improvement Scotland.

- No requirements.

**Recommendation b**
- The service should ensure that all nursing staff receive a role-specific training package and mentor when they begin employment.
Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

Safe systems were in place to manage medicines and staff followed World Health Organization guidelines for Safe Surgery. Staff were aware of their responsibilities in delivering safe care and had appropriate training. We saw some damaged patient equipment and contamination in the care environment. Infection prevention and control systems and processes must comply with national standards.

The service’s governance structure to help deliver safe care was made up of:

- an executive director
- a clinical governance committee
- senior management team meetings, and
- a medical advisory committee.

The service had a dedicated quality and risk manager, and policies and procedures to help manage risks. Staff guidance for identifying and categorising risk was easy to follow. All policies we saw were up to date and a clear review process was in place. Staff described the procedures they followed to report and investigate accidents, incidents and near misses. The service’s records showed evidence of this taking place. We saw that a risk register was in place and regularly reviewed.

We reviewed systems in place to prevent and control infection in the hospital. We saw from the training compliance report that all staff must complete online mandatory infection prevention and control training every year. The infection prevention and control team held a workshop each year that all staff could attend. We saw a copy of the report which heads of departments could access.
on staff compliance with education in their department. In 2019, some staff started to complete NHS Education for Scotland’s Scottish Infection Prevention and Control Education Pathway (SIPCEP) as a trial. We were told the outcome of this trial was yet to be shared.

New staff attended a face-to-face infection prevention and control induction session with the infection prevention and control team.

The ‘Ross Hall Infection Prevention and Control Newsletter’ included current infection prevention and control issues, sharing learning from investigation findings and refreshers on standard infection control precautions.

We saw completed hand hygiene and invasive device compliance audits that ward staff carried out. The infection prevention and control team had a yearly audit programme and audits were saved onto a shared drive accessible to all staff. Audit summaries were shared with the senior management team and, from minutes, we saw audit results were discussed at the hospital infection control committee.

We observed clean and used linen was managed in line with national guidance and waste appropriately stored. All patients we spoke with observed good practice around staff hand hygiene.

The lead pharmacist showed us the service’s systems to support the safe use of medications and staff were trained on medications management. Regular medication management audits were completed and results were shared with the governance structure. From minutes, we saw that incidents, alerts and updates were also discussed at meetings. Staff we spoke with were able to describe how the audits were completed and the results shared.

The laser protection supervisor explained how laser safety was managed in the service. We saw the service had a registered laser protection supervisor who regularly visited the service. Staff completed training and all laser policies and procedures were in place.

We tracked a patient’s journey through theatre. We saw that staff followed World Health Organization guidelines. For example, staff took a ‘surgical pause’ before they started surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments, including tracking and tracing the instruments used. We saw that patients were closely monitored when they were anaesthetised, during the operation and in the recovery room. We saw effective multidisciplinary working with informative staff handovers and good communication.
We saw the service had protocols and equipment to deal with emergency situations and all staff had been trained in emergency procedures.

The service planned a refurbishment of the building to be completed in 12–18 months. Management staff told us this would include installing compliant clinical wash hand basins and replacing the worn patient furniture in the ward areas.

**What needs to improve**

While a refurbishment was planned, patient furniture we saw at the time of our first inspection was unable to be effectively decontaminated. Some of the fabric of the building was in a poor state of repair and some patients we spoke with commented:

- ‘Could be more modern. Yellowed curtains and damage to furniture.’
- ‘There were cobwebs in the waiting room, and the Reception needs to be spruced up.’
- ‘There is dust on the floor behind the chair.’

During the first inspection, we looked at the condition and cleanliness of a variety of patient equipment. We found the following in the theatre department:

- All theatre tables had damaged mattress pieces and had sticky tape and sticky tape residue on the frames.
- Except one, all patient trolleys had damage to the mattresses and ingress of fluid into the inner foam and all had dust contamination.
- The majority of positioning pieces and pressure relieving gel equipment was damaged or contaminated.
- Procedure trolleys were rusty and some other equipment had dust contamination.

During our follow-up inspection, the majority of equipment and procedure trolleys were dust free. In the theatre department, we saw that patient trolley mattresses had been replaced and replacements for all theatre table mattress pieces had been ordered. However, we found damaged pressure relieving gel pieces and positioning pieces that still had sticky tape residue on them.
During our first inspection in the wards, we found:

- Contaminated toilet seat risers, commodes and infusion pumps.
- Sealant around sinks and showers was mouldy and we saw contamination build-up around the base of sink taps.
- While mattresses were clean and intact, bed frames had some contamination.

During our follow-up inspection, we found the majority of reusable equipment was clean and ready for use, including bed frames on the ward. Any exceptions were raised locally. Sealant around showers, baths and sinks had been cleaned and replaced where necessary and taps were clean.

During our first inspection, we saw that the majority of sharps boxes were not correctly labelled, some were over-filled and some were jammed. During our follow-up inspection, sharps boxes were appropriately labelled, not overfilled and had temporary closures engaged. Staff showed us a new sharps audit checklist that was regularly completed.

During our first inspection, we saw that personal protective equipment (gloves, aprons, face masks) was not always worn when required and we saw that it was not always removed following a task. For example, staff left the operating theatre suite wearing gloves and face masks to retrieve an item from a store area and returned to the suite still wearing the same gloves and face masks. During our follow-up inspection, we saw that personal protective equipment was used appropriately.

During our first inspection, we found that incorrect products were used to clean sanitary fittings, clinical hand wash basins and commodes. Blood spills and contamination was not managed in line with national guidance in the wards or theatre department. Following the inspection, we received evidence that immediate action was taken to make sure the correct products were used. Theatre staff had received training on the management of blood spills. During our follow-up inspection, we observed the correct cleaning products used. Processes had been updated to be in line with national guidance for the management of blood and body fluid spillages.

Since our first inspection, staff had received education on cleaning and standard infection control precautions, including personal protective equipment. Clyde ward had introduced an infection control noticeboard to highlight information to staff, such as audit scores and action plans. Monthly topics, such as catheter care, were also highlighted.
A yearly infection prevention and control audit should highlight the issues we found with environmental, equipment and infection prevention and control precautions compliance. At our first inspection, we were told that a theatre department audit scheduled for February 2019 had not been carried out. At our follow-up inspection, we were told that a new audit system had been implemented. However, an audit of the theatre department had still not been carried out at the time of our follow-up inspection (requirement 1).

At our first inspection, a scheduled October 2019 ward audit had not been carried out. Audits that had been completed had not included standard infection control precaution practices. At our follow-up inspection, we saw a completed ward audit and an action plan was in place with the majority of the actions completed.

The service did not have separate laser treatment registers in place and patient registers did not include enough detailed information about the area of treatment, precise exposure and serial number of laser used (recommendation c).

Patients waited in an area in the recovery room before going to theatre. While refurbishment plans had been developed to address the issues, they had not yet been implemented. Curtains were not always closed to maintain patient dignity. The placement of patient trolleys also restricted access to the hand wash basin in this area (recommendation d).

**Requirement 1 – Timescale: by 31 May 2020**

- The provider must ensure:
  
  (a) the patient environment, and patient equipment, is in a good state of repair and is effectively decontaminated to reduce the risk of cross infection.
  
  (b) there are suitable assurance systems in place to monitor standard infection control precautions.

**Recommendation c**

- The service should ensure that all lasers have separate treatment registers and that the patient register contains appropriate information.

**Recommendation d**

- The service should review placement of patients before going to the theatre department.
Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

The service had a records management policy and carried out monthly patient care record audits. Patients had a medical and nursing assessment carried out before treatment being undertaken. Patients care records must include a medical consultation and be fully completed. Patient risk assessments must inform a documented care plan.

A medical and nursing assessment was completed by appropriately trained nurses in the pre-assessment clinic. Patients were sent out a health questionnaire to complete before they attended the pre-assessment clinic. Staff used this in the pre-assessment unit to inform their assessment. While assessments were usually carried out face to face, they could also be done over the telephone. If nurses had concerns after this medical assessment, they could discuss it with a member of medical staff.

The service had combined patient admission and assessment documentation that included patient risk assessments, such as those for venous thromboembolism (blood clots) and pressure area care.

Patients having surgery had a World Health Organization surgical safety checklist completed in their care records. We saw that patients had appropriate care immediately after their treatments in the recovery area and this was recorded in the patient care records. Evidence of the planned follow-up was found in the operation notes the consultant had written in the care record.

The majority of medicine prescription charts and medicines administration records were well completed.

We saw that patient care records were audited as part of the audit programme and had been completed in 2019. We saw that similar issues had been identified during this audit as we had found during our inspection. An action plan had been developed following this audit.

Patient care records were securely stored to maintain confidentiality, in line with the records management policy.

What needs to improve

Three of the four patient care records we reviewed did not have evidence of an initial surgical consultation with the surgeon and not all sections of the record were fully completed. Some forms that made up the records were not used and...
others were duplicated, such as sections that should have been used to document anaesthetic and operating episodes. Patient care records we reviewed were poorly organised and filed. Essential patient information may go missing or be unable to be found quickly in an emergency in unorganised files (requirement 2).

While patient risk assessments were completed, these were not always accurate or used to inform patient care. The rationale for some reassessments being carried out was not clear. For example, a patient identified at risk of pressure area damage should have had the appropriate skin care bundle in place. However, we could not find evidence of this (requirement 3).

The medicine prescription charts we saw did not have a section that could be completed with the date and signature when a medication was discontinued (recommendation e).

Patient consent to share information was not always recorded in patient care records we reviewed. However, the service’s patient registration document did not have an option to refuse consent and so it was unclear if this was mistakenly not recorded or if consent had been refused (recommendation f).

**Requirement 2 – Timescale: by 31 May 2020**
- The provider must ensure that all patient information is recorded in a timely manner in a single patient care record. Patient care records should be maintained to a standard allowing all patient information to be accessed easily.

**Requirement 3 – Timescale: by 31 May 2020**
- The provider must ensure that all patient appropriate risk assessments are completed accurately and that a care plan is developed. Reassessment should be completed in line with best practice and guidance.

**Recommendation e**
- The service should date and sign its medicine prescription charts when a medicine is discontinued.

**Recommendation f**
- The service should make sure that the patient’s consent-to-share information is consistently recorded.
Domain 7 – Workforce management and support

High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings

Quality indicator 7.3 - Communication and team working

We observed good patient handovers and multidisciplinary working. The service communicated information with its staff in a variety of ways. Regular ward staff meetings should be held.

The provider circulated regular staff newsletters. We saw information included recognition of local achievements, updates on new policies and procedures, learning from incidents and celebrating success.

Minutes of hospital meetings were available for staff to view and were shared at departmental meetings. All departments had a representative at the daily communications meetings. This allowed the service to identify any areas of change or concern which could impact on patients and the effectiveness of services. This was then shared with the departments.

The executive director chaired staff forums to share key information and allow staff to give their feedback. Other ways the service shared information included staff noticeboards and email.

Staff handovers we observed were informative and the service had good multidisciplinary communication about patient care and treatment in clinical areas.

Staff we spoke with were enthusiastic about working at the hospital. They stated that it was a good working environment and that they would be happy to raise any concerns.

We observed that interactions between staff and patients were considerate and supportive, with all procedures fully explained. Patients were given enough time to respond and were encouraged to ask questions.

What needs to improve

Ward staff meetings were not regularly held to share information (recommendation g).
- No requirements.

**Recommendation g**
- The service should hold ward staff meetings regularly.
Vision and leadership

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

Staff told us that leadership was visible and approachable. Staff had completed training to increase their knowledge of quality improvement methodologies to help drive change and improvement. Senior staff completed a leadership programme. Infection prevention and control quality assurance systems were not in line with best practice and must be improved. Audit programmes need more oversight from senior staff.

Staff we spoke with told us that leadership was visible, senior staff were very approachable and completed regular walkrounds. From minutes of clinical governance and senior management team meetings, we saw that senior staff had clear areas of responsibility for actions. Some senior staff also attended provider meetings, as well as national and regional committees.

The provider’s learning academy provided leadership training and development opportunities. All senior staff completed a competency leadership programme and staff we spoke with were mostly positive about leadership opportunities they had. They felt that their suggestions were taken seriously and gave examples of how they had been able to influence working practices. For example, in providing training on new equipment, techniques or procedures to improve patient care.

The provider measured key service delivery indicators such as falls, infections and pressure ulcers through a clinical scorecard system. The clinical scorecards of each of the provider’s services were used to benchmark each service’s performance against each other and highlight areas for improvement.

From an adverse event incident we checked, we saw that the service was implementing a new procedure and checks were carried out to make sure it was followed. The provider’s safety bulletin helped to highlight issues identified
across the organisation, promoted best practice and patient safety improvements.

The service had recently implemented different quality improvement models, such as situation-background-assessment-recommendation (SBAR), to improve communication and handovers. Cycles-of-change tools, such as plan-do-study-act (PDSA) had also been introduced to improve quality of care and outcomes for patients. The provider had developed a quality improvement plan, and the quality and risk co-ordinator had held awareness sessions for staff using the PDSA model with the theme of patient safety. We saw that this had been used for learning in different areas, including lessons learnt from a resuscitation scenario.

From minutes, we saw that feedback and complaints were discussed at the heads of department and clinical governance meetings. The executive director reviewed the monthly patient satisfaction report and discussed it at the monthly heads of department meeting. We were told that the aggregated scores from the monthly reports provided the overall satisfaction score for the year.

The service is an active member of the Scottish Independent Hospital Association (SIHA), which provides an opportunity for information sharing and a chance to discuss issues in an open and collaborative way.

**What needs to improve**

Some issues identified at our previous April 2017 inspection were still to be addressed. Work was needed to make sure the service had systems in place to comply with best practice guidance, identify areas of concern and implement improvements. For example, the infection prevention and control team did not have oversight of actions taken if audits that ward staff had completed had low scores (requirement 4).

The infection prevention and control team had a plan of work for 2019. We saw no recorded evidence to document that the majority of audits listed on the plan had been completed. Audits are an assurance measure that would highlight compliance with infection prevention and control national standards (requirement 5).

The service’s patient care record audit had identified a number issues similar to those we had identified but, so far, the service had been unable to resolve those issues. The service should look to develop a more robust audit and compliance cycle for its patient care records to ensure improvement in the standard of its patient record keeping (recommendation h).
Requirement 4 – Timescale: immediate

■ The provider must ensure that the senior management team has oversight of assurance systems and monitors compliance with infection prevention and control improvement actions identified.

Requirement 5 – Timescale: immediate

■ The provider must make sure that any agreed audit programmes not carried out are reported through the risk reporting system.

Recommendation h

■ The service should look to develop a more robust audit and compliance cycle for its patient care records.
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 National Health Services (Scotland) Act 1978, 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.

<table>
<thead>
<tr>
<th>Domain 2 – Impact on people experiencing care, carers and families</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>a The service should review the information and support given to all patients’ post-cancer diagnosis. This will help to ensure that all patients are given the same level of specialised support to make informed choices. This should include a point of contact and appropriate aftercare and follow-up (see page 12).</td>
</tr>
</tbody>
</table>

Health and Social Care Standards: My support, my life. I experience high quality care and support that is right for me. Statement 1.15
## Domain 3 – Impact on staff

### Requirements

None

### Recommendation

**b** The service should ensure that all nursing staff receive a role-specific training package and mentor when they begin employment (see page 13).

Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

## Domain 5 – Delivery of safe, effective, compassionate and person-centred care

### Requirements

1. The provider must ensure:
   (a) the patient environment, and patient equipment, is in a good state of repair and is effectively decontaminated to reduce the risk of cross infection.
   (b) there are suitable assurance systems in place to monitor standard infection control precautions (see page 18).

   Timescale – by 31 May 2020

   *Regulation 3(d)(ii)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

2. The provider must ensure that all patient information is recorded in a timely manner in a single patient care record. Patient care records should be maintained to a standard allowing all patient information to be accessed easily (see page 20).

   Timescale – by 31 May 2020

   *Regulation 4(2)(a)(b)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
**Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)**

3. The provider must ensure that all patient appropriate risk assessments are completed accurately and that a care plan is developed. Reassessment should be completed in line with best practice and guidance (see page 20).

Timescale – by 31 May 2020

*Regulation 13(2)(b)(c)*

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

### Recommendations

c. The service should ensure that all lasers have separate treatment registers and that the patient register contains appropriate information (see page 18).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

d. The service should review placement of patients before going to the theatre department (see page 18).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

This was previously identified as a recommendation in the April 2017 inspection of Ross Hall Hospital

e. The service should date and sign its medicine prescription charts when a medicine is discontinued (see page 20).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

f. The service should make sure that the patient’s consent-to-share information is consistently recorded (see page 20).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

This was previously identified as a recommendation in the April 2017 inspection of Ross Hall Hospital
### Domain 7 – Workforce management and support

**Requirements**

None

**Recommendation**

<table>
<thead>
<tr>
<th>The service should hold ward staff meetings regularly (see page 22).</th>
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</table>

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

### Domain 9 – Quality improvement-focused leadership

**Requirements**

<table>
<thead>
<tr>
<th>4</th>
<th>The provider must ensure that the senior management team has oversight of assurance systems and monitors compliance with infection prevention and control improvement actions identified (see page 25).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timescale</strong> – immediate</td>
<td></td>
</tr>
</tbody>
</table>
| *Regulation 3(d)(i)(ii)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |

<table>
<thead>
<tr>
<th>5</th>
<th>The provider must make sure that any agreed audit programmes not carried out are reported through the risk reporting system (see page 25).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timescale</strong> – immediate</td>
<td></td>
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</tbody>
</table>
| *Regulation 13(1)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011* |

**Recommendation**

<table>
<thead>
<tr>
<th>The service should look to develop a more robust audit and compliance cycle for its patient care records (see page 25).</th>
</tr>
</thead>
</table>

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

**Before inspections**

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

**During inspections**

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

**After inspections**

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require independent healthcare 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.

More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

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

**Telephone:** 0131 623 4300

**Email:** hcis.ihcregulation@nhs.net