Unannounced Inspection Report: Independent Healthcare

Service: Highland Hospice, Inverness
Service Provider: Highland Hospice

1–2 May 2019
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net.
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1 Progress since our last inspection

What the provider had done to meet the requirement we made at our last inspection on 4–5 May 2016

Requirement
The provider must ensure compliance with the Healthcare Improvement Scotland Healthcare Associated Standards 2015 and the recommendations made in the Vale of Leven Inquiry report. To achieve this, the provider must develop an action plan, with timescales, to identify the development work required.

Action taken
The service was compliant with Healthcare Improvement Scotland’s Healthcare Associated Infection (HAI) Standards (February 2015) and carried out audits to ensure standard infection control precautions were implemented. This requirement is met.

What the service had done to meet the recommendations we made at our last inspection on 4–5 May 2016

Recommendation
We recommend that the service should incorporate the facility to clearly record that plans of care have been discussed and agreed with the patient and family. This should be incorporated into phase two of the new electronic care record.

Action taken
The new electronic patient care record allowed staff to record discussions between staff, patients and families. This recommendation is met.

Recommendation
We recommend that the service should incorporate a section to record patient consent to sharing information and with whom. This should be built into the next development phase of the new electronic patient care record.

Action taken
A section about consent to share information had been added to the patients’ admission record. The electronic patient care record also included a section about relevant people the patient or person with power of attorney had agreed information could be shared with. This recommendation is met.
**Recommendation**

_We recommend that the service should ensure that the confidentiality policy is reviewed and updated to refer to Healthcare Improvement Scotland as the service regulator._

**Action taken**

The service had reviewed and updated its confidentiality policy. This had now been incorporated into the service’s information security policy. **This recommendation is met.**

**Recommendation**

_We recommend that the service should finalise the participation policy and provide service users and relatives with opportunities to provide anonymous written feedback using the suggestion boxes and patient feedback forms._

**Action taken**

A patient involvement and stakeholder engagement policy was now in place. Comments boxes in the inpatient unit and day therapy unit allowed patients and relatives to leave anonymous feedback. **This recommendation is met.**

**Recommendation**

_We recommend that the service should update complaints information in their complaints policy and the inpatient information leaflet. The policy should include more information about the timescales for dealing with complaints and the internal escalation procedure and the information leaflet should include more information about the timescales for dealing with complaints and the internal escalation procedure. The address details for Healthcare Improvement Scotland should also be updated._

**Action taken**

The service had developed a new patient information leaflet with a section about how to make a complaint. The service had also updated the existing complaints leaflet to include address details for Healthcare Improvement Scotland and complaint investigation timescales. The complaints policy had also been updated to include address details for Healthcare Improvement Scotland as well as internal escalation procedures and complaints investigation timescales. **This recommendation is met.**
**Recommendation**
*We recommend that the service should resume medication audits.*

**Action taken**
A range of medication audits were now taking place with the frequency depending on risk. Controlled drugs audits were being completed every 3 months and missed dose audits were taking place every year. Actions resulting from the previous medication chart audits had been implemented such as introducing the NHS Highland medication chart into the service in January 2019. This helped to minimise risks associated with the prescribing, administration and recording of medication. **This recommendation is met.**

**Recommendation**
*We recommend that the service should align education to specific job roles.*

**Action taken**
A new improved learning management system was implemented in 2017 which had improved the maintenance of training records. The service was now able to align training and education to specific staff roles. **This recommendation is met.**

**Recommendation**
*We recommend that the service should resume audits for higher risk areas such as those related to medication.*

**Action taken**
Controlled drug and medication chart audits were being completed regularly. Results were discussed and actions agreed through the quality engagement group. **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 Highland Hospice on Wednesday 1 and Thursday 2 May 2019. We spoke with a number of staff, patients and relatives during the inspection.

The inspection team was made up of three inspectors and a clinical pharmacist.

What we found and inspection grades awarded

For Highland Hospice, the following grades have been applied to three key quality indicators.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tbody>
<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
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<tr>
<td>Quality indicator</td>
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<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
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<table>
<thead>
<tr>
<th>Domain 5 – Delivery of safe, effective, compassionate and person-centred care</th>
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<tr>
<td>5.1 - Safe delivery of care</td>
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Key quality indicators inspected (continued)

<table>
<thead>
<tr>
<th>Domain 9 – Quality improvement-focused leadership</th>
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<tr>
<td>Quality indicator</td>
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<td>9.4 - Leadership of improvement and change</td>
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The following additional quality indicators were inspected against during this inspection.

Additional quality indicators inspected (ungraded)

<table>
<thead>
<tr>
<th>Domain 4 – Impact on community</th>
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<tbody>
<tr>
<td>Quality indicator</td>
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<tr>
<td>4.1 - The organisation’s success in working with and engaging the local community</td>
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<table>
<thead>
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<tr>
<td>Quality indicator</td>
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<tr>
<td>5.2 - Assessment and management of people experiencing care</td>
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<th>Domain 7 – Workforce management and support</th>
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<tr>
<td>Quality indicator</td>
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<tr>
<td>7.1 - Staff recruitment, training and development</td>
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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

**What action we expect Highland Hospice to take after our inspection**

This inspection resulted in one requirement and four recommendations. The requirement is 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

Highland Hospice, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Highland Hospice 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 told us they felt involved in their care and were kept informed at all times of all decisions about their care. The service’s participation policy provided information about how the hospice gathered feedback to develop and improve the service.

We saw a wide range of leaflets available at the entrance to the inpatient unit. These included a leaflet with details about the service’s annual review 2017/18, a general information leaflet about the day therapy unit, the complaints leaflet and the spring newsletter. A patient information leaflet had been developed about the new respiratory rehabilitation care programme. This provided information about the benefits for patients receiving care in the inpatient unit and aftercare support in the community.

Patients and relatives were able to give feedback about the service in a variety of ways. Comments boxes were available in the inpatient unit and day therapy unit for patients and relatives to leave feedback.

The service’s participation policy provided information about how the hospice gathered feedback to develop and improve the service. Feedback received from patients attending the day therapy unit showed people really enjoyed meeting others and socialising in a friendly, safe environment.

We were told about a woman’s group which runs once a week in the day therapy unit’s art room. Women supported each other through this group and engaged in therapeutic arts and crafts activities. The group enabled women to develop new creative skills which enhanced their overall wellbeing. We saw a picture displayed in the day therapy unit made by the woman’s group.
We spoke with six patients and two relatives during the inspection. Patients felt they were always kept informed and felt able to ask any questions about their ongoing care. The nurse looking after them always introduced themselves at the beginning of the shift. Some comments from patients included:

- ‘Staff lovely, doctors approachable.’
- ‘Staff very professional, excellent.’
- ‘Amazing place.’
- ‘Staff could not be better, excellent.’

During the inspection, we saw patients were treated with dignity and respect from all staff.

Two new project beds in the service were providing short-term inpatient care for patients who required intensive respiratory rehabilitation and neurological support. The respiratory rehabilitation project had been running since 2018 while the neurological support programme was introduced in early 2019. This was mainly run by the physiotherapist and occupational therapists. The aim was to provide patients living with these conditions the tools to help them to self-manage their condition. During the inspection, a patient being supported by the programme told us they had already felt huge emotional and physical benefits. Once patients were discharged from the service, they continued to be supported with their treatment. The service was also carrying out continual evaluation of the programme to make sure the best possible outcomes could be offered to patients.

All patients were given an information leaflet on admission which referenced the service’s complaints information leaflet. This explained the complaints process and included contact details for Healthcare Improvement Scotland for anyone wishing to make a complaint. Staff were aware of the service’s complaints policy.

- No requirements.
- No recommendations.
Domain 4 – Impact on the community

High performing healthcare organisations have a proactive approach to engaging and working with the local community that inspires public confidence.

Our findings

Quality indicator 4.1 - The organisation’s success in working with and engaging the local community

The service engaged well with the local community. Projects were ongoing which will have a positive impact on the community.

During the inspection, the majority of volunteers we spoke with told us they had been volunteering at the service for many years and enjoyed their roles within and outwith the hospice. The volunteers we spoke with were extremely motivated and keen to be involved in how the service was delivered. They received a monthly newsletter updating them on relevant information about the hospice.

A poster was displayed in the reception area advertising an upcoming ‘Brew ‘n’ Blether’. These informal talks featured guest speakers and took place once a month in the café. A talk was taking place during our inspection.

We were told the service engaged with the community in a variety of ways and had ongoing projects. For example:

- The Crocus Group, a bereavement support service for children and young people living in the Highlands, integrated with the hospice last year. Through this group, social work staff in the service were now involved with school children who had been bereaved. Discussions had taken place with young people about what a bereavement service should look like for the younger person and barriers for accessing this service.

- The Grief Matters Highland project is a partnership between the service, Cruse (a bereavement charity), the Crocus Group and NHS chaplaincy services. It aims to ensure support services are available to everyone across Highland, ranging from outdoors activities to cookery courses. This project was still in the early stages. However, the service had already engaged with many stakeholders. For example, surveys about the types of support people required had been sent to healthcare professionals and community organisations.
The service was working alongside NHS Highland Palliative End of Life Partnerships to find out the needs of the community. This was taking into account not just palliative care diagnosis but also social needs. The service was supporting the partnerships to develop and redesign how they deliver their services to meet the needs of their communities.

- No requirements.
- No recommendations.
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

Patients were cared for in a clean, safe and welcoming environment. Good systems were in place to minimise risks such as the safe management of medication. Improvements needed to be made to how infection prevention and control was audited to show how risks associated with the spread of infection were managed.

The hospice carried out an annual environmental audit and had a statutory maintenance plan. This helped the service assess and, where necessary, carry out repairs. We saw good systems in place to minimise risks associated with the safety of water, fire, gas, electricity and buildings. The service’s maintenance team carried out repairs quickly, whilst external contractors carried out servicing and repairs to specialist equipment where appropriate.

Staff in the inpatient unit had started to carry out a separate environmental audit covering standard infection control precautions to help prevent the cross-transmission of infections. This included hand hygiene, care of the environment and equipment. Individual risk assessments were also carried out every month for each area of the hospice to help make sure all areas of the service were safe.

All of the inpatient unit’s policies and standard operating procedures had been, or were in the process of, being revised. This was to ensure information supported current best practice. Staff were encouraged to read the policies and to attend learning events to develop their knowledge and promote compliance of risk management.

Systems were in place to appropriately record and manage clinical and non-clinical accidents and incidents, including medication incidents. The senior
management team held adverse event meetings and learning events for staff to discuss lessons learned and ways to minimise future risks.

Some staff had completed a national infection prevention and control training programme. Inhouse learning events were now planned to promote good infection prevention and control practice throughout the service.

Staff told us they felt medication was managed well in the service. Ongoing audits helped staff to assess their own practice and report any medication errors. We reviewed four patient care records, medication administration records and relevant policies and found most of the information to be satisfactory.

We found good medicines governance processes were in place across the service. Staff could describe and demonstrate effective systems for the safe and secure handling of medicines including controlled drugs (medications that require to be controlled more strictly such as some types of painkillers). We saw a programme of medication audits was taking place. We also saw examples of audit result reports which were shared with the quality engagement group and practice improvement group. Medicines stock management processes were in place including daily medicines fridge temperature recording. Medical staff were able to show us how the evidence base for treatment was kept up to date with current guidelines and evidence.

The senior management team told us the hospice’s pharmacy service was being reviewed in partnership with NHS Highland. A scoping exercise was in place to define and agree the level of service which would be implemented. A service level agreement was currently in place between the hospice and a local community pharmacy for the supply of medicines.

NHS Highland’s medication chart was introduced into the service in January 2019. We saw this being used in the patient care records we reviewed. Results of a recent audit of medication charts in April 2019 showed that compliance was improving. Results of this audit had been discussed at a recent quality engagement group meeting.

Senior staff described the governance and reporting processes for the management of medicines in the service. The quality engagement group and practice improvement group review audits and clinical quality indicators. They also provided an opportunity to discuss, engage and inform staff on current issues and actions to be taken forward.
**What needs to improve**

Although a number of measures were in place to minimise risks associated with the spread of infection, we found that the collation and reporting of audit results was not clear. This meant it was difficult to know what standard infection control precautions were being audited and how audit results were then used to identify any potential strengths or areas of concern. We also identified that some audits of standard infection control precautions such as hand hygiene were frequently being carried out despite audits demonstrating good compliance (recommendation a).

Some staff had completed training associated with the Scottish Government’s Getting it right for every child (GIRFEC). All staff who are working directly with children or young people will benefit from developing their knowledge of GIRFEC. This would help support them in how to promote the wellbeing of children and young people.

Staff described ongoing work to improve admission and discharge processes for medicines reconciliation (ensuring that a patient’s medication list is as up to date as possible). With the developments in rehabilitation services for patients with respiratory and neurological conditions, patients can often self-administer medication. We discussed with the service the importance of developing clear processes for medicines reconciliation for this new group of patients.

- No requirements.

**Recommendation a**

- We recommend that the service should review the standard infection control precautions audit programme to ensure consistency of reporting, actioning of any issues identified and appropriate frequency of auditing taking place.
Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Staff carried out appropriate assessments to make sure each patient’s needs were met. Where possible, the service empowered patients to manage their own care, particularly in the respiratory and neurological assessment care programmes.

An initial referral discussion took place before patients were admitted to the inpatient unit. This helped to make sure a plan was in place to meet the patient’s needs. A summary about consent to share information had recently been added to the patient’s admission form. Staff encouraged patients and families to tell them of people who they did not want information to be shared with.

Once patients were admitted, nursing staff liaised with medical and allied health professionals, such as occupational health and physiotherapy staff, to develop and complete a person-centred patient care record. Most patients’ care was recorded on the electronic patient care record, with some additional information and assessments recorded in written form. From information boards displaying information about patients in the nurses station, all staff could contribute to and clearly see specific actions required to support patients. The information provided a quick overview of patient care which supported information in the patient care record.

We reviewed four patient care records and found good information showing patients’ needs and preferences were met. We saw their preferred place of death was recorded. Each patient had a set of core care plans to help staff document how the patients’ needs were met. We also saw that patients had specific care plans such as mobility, falls and pressure ulcer management to help make sure risks for patients were minimised.

Staff and patient interactions we saw showed that all staff were busy and attentive to patients’ needs. Patients told us they felt safe and well cared for.

Staff had attended duty of candour training which included how to maintain confidentiality and raise concerns. Staff told us the training helped them to minimise risks in the service by responding quickly to unintended or unexpected incidents in the service.
What needs to improve
Some patient care records were not signed and dated by medical staff. This meant we could not determine when care plans were developed or actioned (requirement 1).

The service recognised that it had not developed a robust system to record anticipatory care planning for patients. This anticipates significant changes in a person’s health and care needs and describes action which could be taken to manage the anticipated problem in the best way. The service was working in partnership with GPs and NHS Highland to promote anticipatory care planning in the hospice and community.

In one patient’s care record, we found the pressure ulcer care plan was not well organised. Information was recorded in various places and was not easy to find. For example, the size of the patient’s pressure ulcer was not immediately clear. We advised staff to ensure all care plans were well organised.

Requirement 1 – Timescale: immediate
- The provider must ensure all patient care records are signed and dated by medical staff to ensure continuity of care is documented.
- No recommendations.

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 7.1 - Staff recruitment, training and development

Suitable recruitment and induction processes were in place. Staff had enough training to carry out their roles and there were good opportunities for staff development. A role-specific induction package should be developed for non-clinical staff.

A recruitment policy and procedures were in place for all staff and volunteers. We reviewed five staff files and saw that all relevant recruitment checks had been completed. All staff completed a corporate induction. A competency framework was in place for clinical staff, including nursing staff, to ensure staff had the necessary skills and knowledge to carry out their role. This was being
reviewed and updated. All posts had a probationary period with reviews carried out at 8 and 18 weeks. Volunteers had a 3-month review process for all those new into volunteer roles.

All staff groups had a programme of face-to-face and online mandatory training. A training matrix was in place to help organise and manage training. A database was used to record attendance and completion of online training. Senior management staff monitored completion of training to make sure that all staff were up to date and had the necessary knowledge and skills to do their role. We saw that all staff were up to date with their training requirements.

Additional role-specific training and education was provided as required and staff had the opportunity to attend external training or conferences in their area of expertise. All staff could attend the annual staff gathering. This event is organised around a particular theme, with presentations given by partner organisations, patients and staff to show innovative ways of working and to review how the service is delivering care. A similar separate volunteer gathering was held for the first time last year. This had been well received by the volunteers who felt it had been a benefit to meet up and network.

Staff appraisals were being carried out on a regular basis. This helped feed into the planning of the training matrix. Staff told us they had enough training to do their job and that they were well staffed.

- ‘The staff to patient ratio seems really good and they bring in extra staff if they need to.’
- ‘The staff all work well together and really support each other, this is the best place I have worked.’

The hospice had been awarded the Silver Investors in People and The Volunteer Friendly award last year. This recognises and rewards those who are good at involving volunteers. The service was now working towards the Gold Investors in People award.

**What needs to improve**
Although all staff completed the corporate induction, non-clinical staff did not have a role-specific induction package. Role specific induction packs for all staff will ensure employees or volunteers have appropriate support to achieve the knowledge and skills required for their role (recommendation b).

Although all staff had annual appraisals, midway reviews or regular one-to-ones were no longer taking place. Some staff told us they were happy to raise any
issues with their line managers themselves. However, this may not suit all staff (recommendation c).

When the competency framework for nursing staff is reviewed and updated, observed peer practice could be included. This will help to make sure that ongoing assessment of nurses’ competency for medicine management takes place.

- No requirements.

**Recommendation b**

- We recommend that the service should develop a formal role-specific induction package for non-clinical staff to make sure they have the appropriate support to gain the knowledge and skills required for their role.

**Recommendation c**

- We recommend that the service should reintroduce regular staff one-to-ones and reviews as part of the staff appraisal process to allow staff the opportunity to discuss progress in their role or any concerns.
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

Leadership was visible and staff felt their suggestions for improvement were considered. Benchmarking was taking place and new initiatives and ways of thinking were encouraged. The service worked well with other organisations to promote and develop its planned strategy.

The service had developed a new strategy for the coming 3 years which had four main themes:

- influence and leadership
- enabling our compassionate communities
- support, mentoring and learning, and
- innovation.

Alongside this, a strategy matrix and a delivery plan had been designed with key performance indicators and ways of measuring defined. This will help to ensure that patients and families continue to experience the best possible care and that they have the support they need no matter where they live in the Highlands.

All audits and incidents were collected into a monthly quality improvement update. An annual report was also developed. A monthly quality engagement group reviewed clinical incidents, audit reports, and policies and procedures. This group provided a report to the healthcare governance committee where the service’s risk register was reviewed and updated as a result of the information received.

A wide range of clinical staff also attended the monthly practice improvement group. This group also received information about the results of audits and any
clinical incidents. Any updates of practice or care were discussed at these meetings. This group was jointly chaired by a charge nurse and a medical consultant and aimed to increase staff awareness and involvement in improving patient care.

Daily safety briefs were shared with staff at each change of shift. These highlighted patients with particular care needs to make sure all staff on shift were aware of particular needs or alerts. Healthcare assistants had been unable to attend the afternoon safety brief as it took place at the patients’ mealtime. As a result, the timing of the safety brief had recently been changed to make sure they were able to attend.

Staff told us that leadership was visible and approachable and there was an ‘open door’ policy. They told us communication was excellent throughout the service. They felt listened to and felt their suggestions for improvement were considered and taken forward. Some had been involved in a number of process mapping meetings to help identify any issues and possible solutions. These had covered different areas of the service including admission and discharge planning, and gift donation.

The service participated in benchmarking exercises coordinated by Hospice UK to identify any gaps and improve how the service was delivered. Every month, the service provided information on bed occupancy levels in the inpatient unit, as well as key performance indicators for medicine errors, pressure ulcer incidence and falls. We noted that the incidence levels were at or below the average reported by similar-sized organisations.

The service was continuing to develop Project ECHO. This aimed to increase hospices’ impact by engaging with communities who often miss out on accessing palliative care input by providing specialist knowledge through mentoring and building communities of practice in remote and rural areas. The service was now classed as a ‘super hub’ and was working in collaboration with Hospice UK and St Luke’s Hospice in Sheffield. They were training other hubs to extend the reach of ECHO to other hospices across Scotland, as well as to other NHS Palliative End of Life Partnerships. The programme was also being extended beyond patients’ palliative care.

**What needs to improve**
In the minutes of the quality engagement group meetings we reviewed, we could not see any record of discussion around any incidents that had taken place in the service (recommendation d).
Although medicine management and infection prevention and control issues were discussed at the quality engagement group, the service could consider making these standing items on the agenda.

The practice improvement group did not record who attended the meetings. Recording this information would help to assess and monitor staff uptake and provide evidence of informal learning for staff.

- No requirements.

**Recommendation d**

- We recommend that the service should record any discussion about incidents that take place in the service in the minutes of the quality engagement group. This will ensure that all staff are fully informed of any outcomes or lessons learned.
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.

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

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<th>Requirement</th>
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<td><strong>1</strong> The provider must ensure all patient care records are signed and dated by medical staff to ensure continuity of care is documented (see page 18).</td>
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Timescale – immediate

*Regulation 4(2)(a)*

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

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<th>Recommendation</th>
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<td><strong>a</strong> We recommend that the service should review the standard infection control precautions audit programme to ensure consistency of reporting, actioning of any issues identified and appropriate frequency of auditing taking place (see page 16).</td>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
## Domain 7 – Workforce management and support

### Requirements

None

### Recommendations

**b** We recommend that the service should develop a formal role-specific induction package for non-clinical staff to make sure they have the appropriate support to gain the knowledge and skills required for their role (see page 20).

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

**c** We recommend that the service should reintroduce regular staff one-to-ones and reviews as part of the staff appraisal process to allow staff the opportunity to discuss progress in their role or any concerns (see page 20).

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 9 – Quality improvement-focused leadership

### Requirements

None

### Recommendation

**d** We recommend that the service should record any discussion about incidents that take place in the service in the minutes of the quality engagement group. This will ensure that all staff are fully informed of any outcomes or lessons learned (see page 23).

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
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

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
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: comments.his@nhs.net