Unannounced Inspection Report: Independent Healthcare

Surehaven - Glasgow | Surehaven Glasgow Ltd
18 and 21 October 2013
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This report was prepared and published by Healthcare Improvement Scotland.

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## Contents

1  Background 5

2  Summary of inspection 7

3  Progress since last inspection 9

4  Key findings 11

Appendix 1 – Requirements and recommendations 19
Appendix 2 – Inspection process 20
Appendix 3 – Inspection process flow chart 22
Appendix 4 – Details of inspection 23
Appendix 5 – The National Care Standards 24
1 Background

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland.

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 2 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (hereafter referred to as ‘the Act’)
- 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.

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act. 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. Please see Appendix 5 for more information about the National Care Standards.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure compliance against expected standards and regulations
- be firm, but fair
- have members of the public on some of 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 independent healthcare services we inspect
- if necessary, inspect services again after we have reported the findings
- publish reports on our inspection findings which will be available to the public 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:** hcis.chiefinspector@nhs.net
2 Summary of inspection

Surehaven - Glasgow is a 17 bed low secure independent psychiatric hospital providing healthcare services in the west of Scotland. The hospital specialises in offering holistic assessment, treatment and rehabilitation for males and females aged 16 to 65 who experience mental ill health, personality disorder, mild learning disability and brain injury. The hospital is registered to accept patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

The hospital is purpose built and two wards. One ward accommodates males and the other females. The rooms are single with en-suite facilities. Each ward has a lounge, quiet room, main bathroom, activities room, dining room and therapy kitchen which patients can use in line with individual care and treatment plans. Each ward has a separate garden area. Visitors have a separate garden area.

We carried out an unannounced inspection to Surehaven - Glasgow on Friday 18 and Monday 21 October 2013.

We assessed the service against three quality themes related to the National Care Standards.

The inspection team was made up of two inspectors. One inspector led the team and was responsible for guiding them and making sure the team members agreed the findings reached. See Appendix 4 for membership of the inspection team visiting Surehaven - Glasgow.

Based on the findings of this inspection, this service has been awarded the following grades (more information on grading can be found on page 19):

**Quality Theme 1 – Quality of care and support:** 5 - Very good  
**Quality Theme 3 – Quality of staffing:** 6 - Excellent  
**Quality Theme 4 – Quality of management and leadership:** 5 - Very good

During the inspection, evidence was gathered from various sources. This included the relevant sections of policies, procedures, records and other documents including:

- patient care records  
- policies on healthcare, adult protection, recruitment and complaints  
- minutes from meetings  
- risk assessments  
- complaints policy, incident recording and management  
- prescription sheets  
- medication recording sheets  
- controlled drug book  
- medication policy  
- medication audits  
- training records, and  
- training plans.

We had discussions with a variety of people employed at Surehaven - Glasgow including:
• the registered manager
• charge nurses
• registered nurses
• healthcare assistants, and
• a psychologist.

We also spoke with people who use the service. The following are some of the comments they gave us:

• ‘Friendly, good at listening.’
• ‘I am receiving a high standard of care which I am very happy with.’
• ‘Only place...that has made me better.’

During the inspection, we observed how staff cared for and worked with people who use the service. We took into account The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011.

Overall, we found evidence in the Surehaven - Glasgow that:

• people who use this service are involved in their care
• people who use this service are treated with respect, and
• staff appeared motivated to look after the people using this service.

We found improvement is needed to ensure that people's views about their care are included in their care programme approach meetings.

This inspection resulted in no requirements and two recommendations. A full list of the recommendations can be found in Appendix 1.

We would like to thank all staff at Surehaven - Glasgow for their assistance during the inspection.
3 Progress since last inspection

What the provider has done to meet the requirements we made at our last inspection on 21 September 2011

Requirement

The provider must review and improve care planning documentation and review service.

This is to ensure that each service user has an up-to-date patient care record which sets out how the service user’s health, safety and welfare needs are to be met and that these are subject to regular review.

Action taken

We have reported on recordkeeping under Quality Statement 1.5. The quality of recordkeeping was graded as very good. This requirement is met.

Requirement

The provider must review and update its infection control policy including the waste policy, in line with up-to-date legislation. This is to ensure that service users' health, safety and welfare needs are met.

Action taken

We saw a policy is now in place. This requirement is met.
What the service has done to meet the recommendations we made at our last inspection 21 September 2011

**Recommendation**

We recommend that the provider develops a formal participation strategy to guide how service users will be involved in service development and delivery.

**Action taken**

We found a formal strategy is now in place. This recommendation is met.

**Recommendation**

The provider should ensure that the section for allergies/drugs in the medicine recording sheet is completed. For completeness and accuracy, this field should have some entry recorded to demonstrate it has been considered, for instance to record ‘No known allergies/contraindications.’

**Action taken**

We looked at six medicine recording sheets and found that this section for allergies/drugs was completed on all of them. This recommendation is met.

**Recommendation**

The provider should ensure that all risk assessments include a date for review. This means that there is ongoing monitoring of both the risk and control measures.

**Action taken**

We looked at examples of risk assessments and saw that all of them had a review date. This recommendation is met.

**Recommendation**

The provider should ensure that risk assessment processes are robust and take into account all hazards. This will ensure that all aspects of staff and patient safety are considered.

**Action taken**

We saw a large number of risk assessments in place covering numerous aspects of the service. This recommendation is met.

**Recommendation**

The provider should reorganise the sluices to ensure better segregation of clean and dirty equipment and activity and improve access to hand washing facilities.

**Action Taken**

We looked at the sluices and saw that they were set up in a way that allowed for adequate segregation and access to hand washing. This recommendation is met.
4 Key findings

Quality Theme 1

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

During the inspection, we spoke with staff about involving people who use this service in their own care. We spoke with people who use this service and they told us that they felt involved in their care and have input into their care plans. They told us that their key worker would talk to them about their care and ask their opinions. They were also able to give their ideas to the consultant psychiatrist for the multidisciplinary meeting. This is a meeting where doctors, nurses and occupational therapists meet to discuss peoples’ care.

The service holds a regular community meeting. This is a meeting that allows people who use this service to talk about how the service is run and make suggestions about how it could run better. We saw evidence where suggestions had been taken on board and changes made. We also saw that when the service was unable to make the suggested changes, they explained why. There was feedback posters showing what people asked for and the response from the service displayed in the hospital.

The service has an activities programme. This is a programme that people can follow to help provide structure to their day while they are in the hospital. It can also involve activities that teach them new skills to help towards their rehabilitation, for example cooking sessions. The people we spoke with told us that they were able to give their suggestions about the programme and the sessions they wanted.

We saw that people who use this service are provided questionnaires. The questionnaires ask for people’s opinions on different aspects of the service. Examples of questionnaires include:

- level of satisfaction with services provided
- external services used
- protection of vulnerable adults, and
- What three things would make the ward a better place.

We saw evidence that the feedback from the questionnaires is discussed and action plans put in place to make improvements.

We saw that the service involved people in the recruitment of new staff and asked them their opinion on the candidates.

A recent development is for people using the service to attend staff meetings. We saw from the minutes that people using the service are involved in clinical governance meetings. The service has tried some different ways to involve the relatives and carers of people who use the service. They have held barbeques and coffee mornings to try and encourage people to come and spend some time in the service. The staff can then use this as an opportunity to ask people about their opinions on how the service is run.
Areas for improvement
The service has identified themselves that they are still finding it difficult to involve relatives and carers in giving their opinions on how the service is run. They are planning to look at different ways they can increase participation from this group of people.

We saw in the minutes of the community meetings that the meetings are better attended and people on the female ward are more involved than the people on the male ward. The service should look at ways to engage with people who are reluctant to be involved in community meetings to ensure they are given opportunities to give their opinions and influence the care they receive. We will follow this up at future inspections.

- No requirements.
- No recommendations.

Quality Statement 1.4
We are confident that within our service, all medication is managed during the service user’s journey to maximise the benefits and minimise any risk. Medicines management is supported by legislation relating to medicine (where appropriate Scottish legislation) and current best practice.

Grade awarded for this statement: 5 - Very good
During the inspection, we looked at eight prescription sheets. We found that all the prescriptions had:

- a photograph to help identify the correct person
- the person’s name and date of birth clearly written
- been signed by the prescriber
- the name of the medication to be given written legibly, and
- the route identified, for example to be given by mouth or injection.

When the person using the service was on a high dose of anti-psychotic medication, we saw forms in place to monitor this. Being on high doses of this type of medication can affect a person’s health. It is important that their health is monitored closely to allow any concerns to be highlighted quickly. We saw that the people on high doses of this type of medication had an electrocardiogram (ECG) test before starting on the medication. This test shows how well a person’s heart is working. It helps to identify if the person would be at risk taking high doses of medication. We also saw that people’s health was monitored during the time they were taking the medication.

The service has a rapid tranquilisation policy in place. Rapid tranquillisation is used when staff have to give people medication to sedate them in an emergency situation. The policy sets out the process staff should follow if they have to sedate people. The policy outlines the need for continued physical monitoring of the person for a period after the medication has been given. We looked at paperwork used after medication was given, for this purpose, and saw that staff had continued to monitor the person for the time set out in the policy. When people are given medication in an emergency, it is usually given orally or by injection. It is good practice to try and give it orally and only give it by injection as a last resort. On the prescriptions we looked at, we saw that there was always the option to give the medication orally or by injection. We saw examples where the medication had been orally, which
suggests staff in the service will try and use this option first. Staff we spoke with told us that they would always try and use the oral option first.

We looked at the controlled drugs recording book in the service. Controlled drugs are medications that have been identified as needing stricter controls. We saw that the stock levels were checked by two staff between shifts to ensure they were correct. This allows any discrepancies to be identified quickly and investigated. We saw that the controlled drugs book was completed correctly.

Ongoing training is available for staff. We also saw that staff go through a competency check every six months. Competency checks are when staff are observed administering medication to ensure they are doing it correctly. The observation includes a minimum of two separate drug rounds. During the observation, the person observing is checking that the nurse:

- correctly identifies the person receiving the medication
- identifies the correct medication and correct dose of medication, and
- correctly record that the medication has been given.

A policy is in place for staff to follow if they make a medication error. Staff we spoke with were able to tell he what they would do if they made an error and if necessary, seeking immediate medical advice. We saw that when staff do make an error, this is discussed with the staff member and any areas for learning or further training are identified.

- No requirements.
- No recommendations.

**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: 5 - Very good**

We looked at three healthcare records during the inspection. We found that these were mostly completed to a very good standard.

We saw that people had numerous care plans in place to describe how their care should be given. Most of the care plans were detailed and were personalised. They contained individual details of how people should be looked after. We also saw that people had been involved in writing their own care plans and had signed to say that they agreed with them.

We looked at four incident forms during the inspection. We then looked at the person’s healthcare record to see how these incidents were documented. We saw that the notes were detailed. They outlined the events leading up to the incident, what action staff took and why they took the action and the outcome. We also saw that care plans were in place to help guide staff on how to look after people during any incidents.
Areas for improvement

Although the healthcare records we looked at were mostly completed to a very good standard, improvements could be made in some areas. Some of the care plans we looked at lacked detail. For example, one care plan described that a person may display signs of anger, but did not elaborate on what those signs were. It would be beneficial for staff who may not know the person well to have access to this information. We will continue to monitor the quality of the healthcare records at future inspections.

We looked at the minutes for people’s care programme approach meetings. A care programme approach meeting is held for people who have complex needs and have a number of people involved in their care. The meeting allows people to discuss the person’s care and share information. The person the meeting is about should be involved in the process if they choose. The minutes we looked at did not reflect if the person had attended the meeting or not and it was difficult to see from the minutes if their views had been taken into account (see recommendation a).

■ No requirements.

Recommendation a

■ We recommend that Surehaven - Glasgow should ensure that people’s views about their care are included in their care programme approach meetings. The minutes of the meeting should reflect this involvement.

Quality Statement 1.7

We are confident that the quality of service users' care will benefit from regular review of clinical practice within the service.

Grade awarded for this statement: 6 - Excellent

We saw that the service audits various aspects of clinical practice. Audits include:

- medication
- healthcare records, and
- Incidents.

We saw that the incident audits look at the practice of staff during the incident including the use of restraint and medication during the incident.

Staff we spoke with told us that they felt well supported working in the service. They told us that it can be a challenging environment to work in at times. Support to staff can be through supervision. Supervision is when staff are given the opportunity to discuss their performance at work and their clinical practice. It also allows managers and colleagues to give feedback. Staff have the opportunity to attend management, clinical and group supervision in the service. Group supervision is when staff have come together to reflect on their own practice and discuss how they look after the people who use the service.

We saw that staff are given the opportunity to have a debrief after any major incidents. A debrief allows all staff involved in an incident to discuss what happened, look at any areas of learning and discuss what they could have done differently.

■ No requirements.
Quality Theme 3

Quality Statement 3.1
We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.

Grade awarded for this statement: 6 - Excellent
We spoke with several staff during the inspection. The staff we spoke with all appeared very motivated. They spoke positively about their work and about the people they look after. We saw lots of training available to staff. We saw that training had been put in place which was designed around the nature of illness people present with. The training includes:

- counselling skills
- compassionate minds
- psychological trauma
- personality disorder, and
- trauma.

We spoke with the psychologist in the service who delivers a lot of the training programme. The training covers the theory behind these topics and also uses case studies to help staff relate the theory to the people they are looking after. This training is mandatory for all staff in the service who look after people directly.

The service has a range of policies and procedures in place. Staff were aware of how to access these if required.

We looked at two specific examples of people using the service who had positive outcomes. Both people had spent significant amounts of time in different hospitals before coming to the service. Both have been supported to be able to be discharged and live in their own home within the community.

- No requirements.
- No recommendations.

Quality Statement 3.4
We ensure that everyone working in the service has an ethos of respect towards service users and each other.

Grade awarded for this statement: 6 - Excellent
We spoke with several people who use the service. They all told us that they felt respected by staff. The feedback we received was very positive. During the inspection, we saw staff interacting positively with people. We did not hear any inappropriate language. The staff we spoke with during the inspection spoke very positively about the people they look after.

The staff we spoke with also spoke positively about their working environment. They felt valued and well supported by the management team. They told us that there was an open...
culture in the service where they felt able to challenge colleagues if necessary. Staff told us they felt respected and supported by colleagues. All the staff we spoke with were aware of the whistle blowing policy and felt able to use it if necessary. A whistle blowing policy sets out how staff can bring any areas of concern to the attention of the management team.

Other policies available to staff include:

• professional and personal boundaries
• a code of confidentiality, and
• safe and supportive observations.

All of the policies are written with a strong user focus and emphasise the need to respect users and maintain their dignity during all interactions with them.

There are several private areas within the hospital where people using the service are able to meet with staff or their family and friends.

The service also asks people who use the service and staff to fill out an attitude questionnaire. This allows people to feedback any concerns about the way staff treat them. The feedback on the questionnaires we looked at was positive.

- No requirements.
- No recommendations.

Quality Theme 4

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

There is a yearly audit plan in the service. The audits include:

• health and safety
• pharmacy
• infection control
• adult support and protection, and
• Mental Health Act legislation.

We also saw that monthly audits are carried out on each ward. The ward level audits include:

• patients’ rights audit
• use of depot medication
• clinical notes
• care plans
• use of high dose anti-psychotic medication, and
• opportunity for people to have 1:1 time with staff.

We saw that where areas for improvement are identified, action plans are put in place which detail who should complete the action and when it should be completed. The person responsible then signs it to say that the action has been taken.

We saw that the service audits all incidents. The audits include:

• the type of incident
• the date and time of the incident
• what staff were involved
• the gender mix of the staff
• whether restraint was used
• whether medication was used.

The results of the audits are then looked at to see if there are any patterns. For example, if certain types of incident happen at specific times of the day or when certain staff are on duty. If there are any patterns then the service can put measures in place to try and reduce the number of incidents.

There is a clinical governance structure within the service which includes:

• clinical governance meetings
• security and risk meetings
• health and safety meetings, and
• a range of audits.

We looked at the minutes from the clinical governance meeting. The meeting agenda includes:

• feedback from other governance meetings
• risk management
• audit results
• staff training and development, and
• feedback from people using the service.

We looked at the outcome of a recent peer review of the service. A peer review is when people from a different service come and look at how well the service is meeting a set of standards. The peer review process was very detailed and covered lots of different aspects that the service provided. We saw an action plan was in place detailing what improvements the service had to make following the review.

Area for improvement

While we saw that the minutes of some meetings detailed the actions required and who was responsible, this was not always the case. It is important that any areas for action are clearly identified as this will allow the service to make sure that any improvements are made (see recommendation b).
No requirements.

Recommendation b

We recommend that Surehaven - Glasgow should ensure that the minutes for all meetings are reviewed to make clear when any actions are identified and who is responsible for taking the actions.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Quality Statement 1.5

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<th>Requirements</th>
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<tr>
<td><strong>Recommendation</strong></td>
<td><strong>We recommend that Surehaven - Glasgow should:</strong></td>
</tr>
<tr>
<td>a</td>
<td>ensure that people’s views about their care are included in their care programme approach meetings. The minutes of the meeting should reflect this involvement.</td>
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<td>National Care Standard 9 - Expressing Your Views [Independent Hospitals]</td>
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### Quality Statement 4.4

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<th>Requirements</th>
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</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td><strong>We recommend that Surehaven - Glasgow should:</strong></td>
</tr>
<tr>
<td>b</td>
<td>ensure that the minutes for all meetings are reviewed to make clear when any actions are identified and who is responsible for taking the actions.</td>
</tr>
<tr>
<td>National Care Standard 12 - Clinical Effectiveness [Independent Hospitals]</td>
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Appendix 2 – Inspection process

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 the flow chart in Appendix 3.

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 service provider in relation to their improvement action plan. This will take place no later than 16 weeks after the inspection. The exact timing will depend on the severity of the issues highlighted by the inspection and the impact on patient care.

The follow-up activity will be determined by the risk presented and may involve one or more of the following:

- a further announced or unannounced inspection
- a targeted announced or unannounced inspection looking at specific areas of concern
- an on-site meeting
- a meeting by 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 an inspection.

Depending on the format and findings of the follow-up activity, we may publish a written report.

Appendix 3 – Inspection process flow chart

Before inspection visit

Service undertakes self-assessment exercise and submits outcome to Healthcare Improvement Scotland

↓

Self-assessment submission is reviewed to help inform and prepare for on-site inspections

↓

During inspection visit

Arrive at service

↓

Inspections of areas

↓

Discussions with senior staff and/or operational staff, people who use the service and their carers

↓

Feedback with service

↓

Further inspection of service areas of significant concern identified

↓

After inspection visit(s)

Draft report produced and sent to service to check for factual accuracy

↓

Report published

↓

Follow-up activity to ensure improvement actions are completed
Appendix 4 – Details of inspection

The inspection to Surehaven - Glasgow was conducted on Friday 18 and Monday 21 October 2013.

The inspection team consisted of the following members:

Gareth Marr
Senior Inspector

Gill Swapp
Inspector
Appendix 5 – The National Care Standards

The National Care Standards set out the standards that people who use independent healthcare services in Scotland should expect. The aim is to make sure that you receive the same high quality of service no matter where you live.

Different types of service have different National Care Standards. There are Care Standards for:

- independent hospitals
- independent specialist clinics
- independent medical consultant and general practitioner services, and
- hospice care.

When we inspect a care service we take into account the National Care Standards that the service should provide.

The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.

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www.healthcareimprovementscotland.org

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