Unannounced Inspection Report: Independent Healthcare

Service: The Priory Hospital - Glasgow
Service Provider: Priory Healthcare Limited

23–24 July 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
Contents

1 Progress since our last inspection 4

2 A summary of our inspection 8

3 What we found during our inspection 11

Appendix 1 – Requirements and recommendations 23
Appendix 2 – About our inspections 25
1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 9–10 January 2018

Recommendation
We recommend that the service should change the wording in the complaints booklet and website to inform prospective complainants that they can contact Healthcare Improvement Scotland at any stage in the complaints process.

Action taken
The service had updated its complaints booklet and website to include details for prospective complainants to complain directly to Healthcare improvement Scotland. **This recommendation is met.**

Recommendation
We recommend that the service should review the contents of the mental health legislation folder allocated to each patient.

Action taken
Staff showed us the updated mental health legislation folder. Patients’ legal status was clearly stated in their care plans and all forms relating to mental health legislation were filed in their folder. **This recommendation is met.**

Recommendation
We recommend that the service should amend its policies to include Scottish mental health legislation.

Action taken
The service was systematically reviewing all policies and procedures in line with current Scottish legislation. Although the majority of these had been reviewed, this work was not yet complete. **This recommendation is not met** and has been carried forward (see Appendix 1).

Recommendation
We recommend that the service should amend its consent forms to ensure that a staff member can confirm that informed consent has been obtained.

Action taken
The service had amended its consent forms. Consent forms were present in all patient care records we reviewed and were signed appropriately to show that informed consent had been obtained. **This recommendation is met.**
Recommendation
We recommend that the service should make sure the competencies of each member of staff who administers medication are assessed yearly.

Action taken
We spoke with members of staff who administer medication and saw their competencies were evaluated each year. This recommendation is met.

Recommendation
We recommend that the service should ensure staff receive control and restraint training during their induction. This will help manage patients’ care safely.

Action taken
All staff had completed this training as part of their induction training programme. This recommendation is met.

Recommendation
We recommend that the service should carry out repairs as soon as possible.

Action taken
We spoke with the estates manager and saw the process for reporting and carrying out repairs. We saw that each reported repair was carried out within a reasonable timescale. This recommendation is met.

Recommendation
We recommend that the service should engage with staff and patients to establish an agreed understanding of acceptable levels of patient belongings and how they are stored in patient bedrooms.

Action taken
The service had set a threshold for the acceptable level of patient belongings kept in patient rooms. This recommendation is met.

Recommendation
We recommend that the service should frequently clean all carpets and replace them if they cannot be cleaned effectively.

Action taken
The service had introduced a regular programme of carpet cleaning. We saw that carpets were clean throughout the hospital. This recommendation is met.
Recommendation
We recommend that the service should replace all its clinical hand wash basins at the next refurbishment so that they comply with SHTM 64.

Action taken
The service told us it will upgrade the clinical hand wash basins as part of a planned programme of refurbishment of the wards. This recommendation is not met and has been carried forward (see Appendix 1).

Recommendation
We recommend that the service should develop suitable training for staff which will provide them with the knowledge they need to manage patients who have complex eating disorders.

Action taken
The service had developed a 2-day training programme to provide staff with the knowledge to support and manage patients with complex eating disorders. This training was based on national best practice guidance. Staffing levels had increased from 30 to 90 staff members since October 2018. The service had provided three training sessions to staff since February 2019. Approximately 50% of staff have had the opportunity to attend this training. This recommendation is not met and has been carried forward (see Appendix 1).

Recommendation
We recommend that the service should develop and implement regular staff meetings. Minutes of the meeting should also be shared with staff in the service.

Action taken
Staff told us two team meetings were held once a month to cover both day and nightshift staff. Staff had the option to attend meetings on their days off and were paid for their time. Minutes were made available to all staff. This recommendation is met.

Recommendation
We recommend that the service should ensure staff receive appropriate training to equip them with the skills required to carry out their roles effectively.

Action taken
This recommendation is reported in Quality Indicator 7.1. This recommendation is met.
**Recommendation**

*We recommend that the service should ensure all audits carried out are checked to verify their accuracy.*

**Action taken**

A comprehensive audit programme was in place. We saw that when audits identified gaps, action was taken to make improvements. We also saw any actions identified from audits were discussed at the risk management meetings held every month. **This recommendation is met.**

**Recommendation**

*We recommend that the service should allocate a timescale to complete any actions resulting from audits or quality assurance processes.*

**Action taken**

Actions identified through audits were discussed at the risk management meetings held every month. Action plans were agreed with timescales noted. **This recommendation is met.**

**Recommendation**

*We recommend that the service should make sure it communicates the findings of the most recent staff survey.*

**Action taken**

Staff told us the service had circulated a staff survey. However, not all staff were aware of the findings of the staff survey. The service reported that, although it had issued the results of the survey, some staff had chosen not to read them. **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 The Priory Hospital - Glasgow on Tuesday 23 and Wednesday 24 July 2019. We spoke with a number of staff and patients during the inspection.

The inspection team was made up of three inspectors.

What we found and inspection grades awarded

For The Priory Hospital - Glasgow, 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>Domain 2 – Impact on people experiencing care, carers and families</td>
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<tr>
<td>Quality indicator</td>
</tr>
<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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<tbody>
<tr>
<td>5.1 - Safe delivery of care</td>
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</table>
### Key quality indicators inspected (continued)

#### 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</td>
<td>The service had a visible and supportive leadership team that was open to new ideas and change. Time and effort was invested in reviewing policies, procedures, systems and processes to identify areas for improvement. This helped to ensure that quality improvement was a core part of delivering the service.</td>
<td>☑️ ☑️ Good</td>
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<tr>
<td>of improvement</td>
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<tr>
<td>and change</td>
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The following additional quality indicators were inspected against during this inspection.

### Additional quality indicators inspected (ungraded)

#### 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>5.2 - Assessment</td>
<td>Each patient had a detailed assessment carried out which linked to a comprehensive care plan. Regular multidisciplinary reviews took place which patients contributed to. Views from patients could be more detailed in their care records.</td>
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<td>and management of</td>
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<td>people experiencing</td>
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<td>care</td>
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#### Domain 7 – Workforce management and support

<table>
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<tr>
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<th>Summary findings</th>
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<tr>
<td>7.1 - Staff</td>
<td>Appropriate processes were in place to ensure the safe and effective recruitment of staff. Staff had a period of induction, and ongoing training and development took place.</td>
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<td>recruitment,</td>
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<td>training and</td>
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<td>development</td>
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<td>7.3 - Communication</td>
<td>Considerable efforts were made to promote effective communication between staff, patients, families and carers. Regular patient and staff meetings were held. All stakeholders were invited to participate in multidisciplinary team meetings and case conferences. Patients told us the information they received from staff between different shifts was not always consistent.</td>
</tr>
<tr>
<td>and team working</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 Priory Healthcare Limited to take after our inspection**

This inspection resulted in two recommendations. See Appendix 1 for a full list of the 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

We would like to thank all staff at The Priory Hospital - Glasgow 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 were very happy with the care and treatment offered. They told us staff treated them with dignity and respect, they had sufficient opportunities to provide feedback to the service, and to contribute to how their care and treatment was delivered. The service was continuing to consider ways to make the service safer and more patient-centred.

On admission, patients were provided with a handbook as part of their orientation. This contained service rules and expectations, and included satisfaction surveys for patients to complete on admission and again on discharge. A complaints and compliments form was included as part of the admission contract. Patients were also able to show us the suggestion boxes which were visible around the hospital and knew how to access the complaints booklet should they wish to make a formal complaint. The complaints booklet clearly stated how the service would respond to complaints and included details on how to complain directly to Healthcare improvement Scotland. The service kept a record of complaints. We saw that the service complied with its own complaints policy, and that all complaints were dealt with correctly and outcomes were recorded.

Since our last inspection in January 2018, the service had updated patient consent forms to ensure that it was clear to staff that patients had provided informed consent. A representative from the advocacy service attended the service once a week. They offered patients additional support and helped to address any concerns about their care and treatment. The advocacy service also supported patients with mental health legislation. Patients were given the opportunity to elect a named person to act on their behalf and were supported to draw up advance statements. This set out their wishes, beliefs and values about their future care. Patients who were detained (people who need
additional support who have been admitted under the Mental Health (Care and Treatment) (Scotland) Act 2003) that we spoke with told us they were happy with the information provided about their detention. This information was recorded in patients’ mental health legislation folders and in their care plans.

Staff told us the service faced significant challenges involving patients’ families and carers, particularly for the patients in the eating disorders unit who were referred from all over the United Kingdom. The service had recently updated its patient and carer involvement strategy. This set out the service’s processes for identifying patient and carer expectations and how it intended to meet these. A member of staff had been nominated as a carer’s champion to co-ordinate implementation of the strategy. We were told the service was exploring the use of technology to enhance family and carer involvement. For example, video-conferencing was going to be used to facilitate carers meetings and support groups. We were encouraged that the service was already successfully using video-conferencing to involve families and carers in multidisciplinary team meetings and case conferences. We were also given examples of both medical and senior nursing staff attending the service at the weekend to meet patients’ relatives and carers who may have travelled long distances.

Patients told us they had regular one-to-one meetings with their named nurses. This provided an opportunity to discuss more personal issues about their care and treatment. Patients were happy with their involvement in how their care was planned and told us they were always given the opportunity to attend and contribute to multidisciplinary team meetings. Patient meetings were also held once a week in both wards. This provided a forum for patients to discuss any general concerns. A representative from the addictions patients’ forum also attended the clinical governance meeting with senior managers to discuss issues that were important to the patient group. This was good practice.

Patient feedback was mostly positive. All patients we spoke with were happy with the facilities and level of service provided. However, where concerns were raised, the staff response and action taken was displayed both on staff noticeboards and ‘You said we did’ noticeboards in the patient areas. Overall, patients reported they were happy with the level of feedback they received from staff. Patients we spoke with gave us an example of staff following duty of candour procedures and apologising after things had gone wrong.

**What needs to improve**

The service had begun work to introduce the ‘safewards’ initiative which aims to reduce incidents of violence and aggression on wards by agreeing mutual expectations between patients and staff. At the time of our inspection, a champion had been appointed to take this work forward and a staff training
session had been held. While this was a positive start, it was too early to assess impact.

- 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

The service continuously strived to provide a safe environment for patients. Staff had a good understanding of any risks they may encounter through a patients’ illness or behaviour. A risk assessment and management plan should be in place for patients on pass or home leave.

We saw that the environment was clean. Each ward area had facilities for staff and visitors to clean their hands when entering and leaving the ward areas. Adequate personal protective equipment, such as disposable gloves and aprons, were available, and an infection prevention and control audit was carried out every 6 months.

The estates manager showed us the safety checks carried out for the water, fire and security systems. A detailed plan was in place to ensure that any safety issues raised were repaired quickly. The estates manager was responsible for making sure that any external contractors were inducted and supervised to ensure patient safety and confidentiality.

We saw that some parts of the hospital were in need of redecoration. We were told the service had recently been given permission to complete an extensive refurbishment.

The service had a clear policy on protecting vulnerable patient groups. A member of staff was responsible for overseeing that the correct procedures were followed should any issues arrive. We saw evidence that the policy had been followed and that Healthcare Improvement Scotland had received notifications of certain incidents as required.
We saw that each patient had a treatment plan. This would be put in place if they became unwell. Some patients who were detained had voluntary treatment plans and others had a treatment plan compiled for them. We saw that these followed best practice guidelines and were all in date.

Each patient was asked to attend the weekly ward round. At this meeting, the patient’s progress and future care planning was discussed. From the minutes of these meetings, we saw that patient safety was treated as a matter of priority. Care plans, risk assessments and management plans were being updated as required. We saw that the service tried to ensure that the balance of providing the least restrictive care was considered against any serious risk factors for the patient.

A national and local audit programme was in place. The national programme was directed by the quality and compliance team, and included topics such as adult and child protection, ligature awareness, and infection prevention and control. Results from these audits were shared with the provider. The local programme included topics such as the completion of patient care records. An audit meeting was held every month to discuss the results of audits from both programmes. Actions were agreed and taken forward with timescales.

The hospital used a national pharmacy service. This service audited the hospital’s medicine administration and recording sheets, the tidiness of treatment rooms and the hospital’s overall compliance with medicines used for a psychiatric illness in line with the recommended guidelines published by the British National Formulary and the Medicines and Healthcare products Regulatory Agency. It submitted the results of these audits to both the service and the provider. This allowed the provider to compare the service’s performance against other services in the provider group and make any recommendations for improvement.

Each ward had a medical emergency trolley. We saw that the contents and equipment were checked every week. Staff had received training in adult life support, and were knowledgeable about the emergency equipment. Staff we spoke with were confident they would be able to respond to an emergency quickly.

We observed staff and patient interactions, and spoke with patients. The patients’ views varied, but we saw a direct link with a patient’s view of the service and how their recovery was progressing. Staff interactions were calm and thoughtful with good relationships evident between staff and patients.
What needs to improve

Although we saw that inpatient risk assessments were in place for each patient, additional risk assessments and management plans were not in place for patients who were out on pass or on home leave (recommendation a).

- No requirements.

Recommendation a

- The service should ensure a risk assessment and management plan is put in place for patients who are out on pass and home leave.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Each patient had a detailed assessment carried out which linked to a comprehensive care plan. Regular multidisciplinary reviews took place which patients contributed to. Views from patients could be more detailed in their care records.

We examined 10 patient care records across three wards. We saw that each care plan provided comprehensive information and was divided into four areas:

- keeping connected
- keeping healthy
- keeping well, and
- keeping safe.

This allowed the service to plan for each patient’s biological, psychological and social care needs, and allowed for continual monitoring of a patient’s condition. We saw that each staff group working with the patient, including nurses, dieticians and doctors, had their own comprehensive assessment and management plan in place. These plans were discussed to ensure they complemented each other at the weekly ward round.

A staff handover took place at the beginning of each shift. A handover sheet recorded each patient’s current observation status and how well they were responding to treatment. The sheet also included any special or specific procedures which were to be carried out. Staff we spoke with felt there was good communication between each staff group and that they had an opportunity to discuss any challenges together at the weekly ward round.
Each patient was risk assessed every day. Should staff feel that a patient required extra support, they increased the observation levels (the number of staff needed to keep the patient safe). This can include ensuring that a member of staff has a visual and verbal contact with the patient for a specified timescale. This could be for a variety of reasons including a risk of self-harm, absconding or resistance to their treatment plan. We saw these interactions were recorded. If a member of staff was required to constantly stay with a patient, they were issued with a radio so they could stay in touch with other staff. At the time of the inspection, we saw that one ward had adopted a locked door policy. We saw that any visitors were reminded of this and how they were expected to comply with keeping the patients safe.

The dieticians we spoke with explained their role and how they contributed to the multidisciplinary team working. They explained the strategies they used to overcome some patients resistance to treatment and how they constructed a safe meal plan. Risk assessments were also developed to avoid complications if a patient had not been eating correctly for a period of time. They monitored the patients closely for the first week, contributed to the weekly ward rounds and had one-to-one meetings with each patient. Patients were also directly involved in creating their meal plans.

**What needs to improve**

The electronic care plans had been updated to be more person-centred. They contained sections where staff could record that the patient’s views had been taken account of. However, some of the recorded views were quite limited and would benefit from more detailed information.

- No requirements.
- 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**

Appropriate processes were in place to ensure the safe and effective recruitment of staff. Staff had a period of induction, and ongoing training and development took place.
We reviewed four staff files and saw that appropriate references and Protecting Vulnerable Groups (PVG) checks were in place. Staff qualification certificates were held on file, and job descriptions, interview records and contracts were in place. We saw that the occupational health status of all staff was checked and recorded.

Two independent practitioners had been granted practicing privileges by the provider (staff not employed directly by the provider but given permission to work in the service). We saw that appropriate checks had been completed, including PVG checks, references, professional registration status, revalidation status, indemnity insurance checks and occupational health status.

Annual professional registration and revalidation status checks were in place for all clinical staff.

All staff carried out an induction programme. A checklist was used to ensure this was completed. Mandatory topics for new staff included fire safety, infection prevention and control, managing challenging behavior and safeguarding vulnerable adults. Staff also completed a 6-month probationary period, and met regularly with their line manager during this time.

Continuing professional training and development opportunities were available for staff. This included education in updated policies and procedures, and other core topics such as control and restraint of patients. Staff had also successfully delivered three training sessions to their peers this year, for example on the ‘safewards’ model.

The service was supporting and engaging staff to view supervision as an ongoing process, rather than just for when things go wrong. Staff were given an opportunity to reflect on their practice during their monthly meetings with their line manager. Staff had annual appraisals with their line manager, and were encouraged to look at ways to develop their roles. For example, one staff member was being supported to become a champion for the physical health care of patients, and another staff member was training staff in patient nutrition.

What needs to improve
As well as the PVG scheme informing an employer whether an individual is barred from working with protected adults and/or children, the certificate provides a point in time check of an individual’s criminal convictions history. A system should be introduced to obtain a PVG update for staff at regular intervals (recommendation b).
No requirements.

**Recommendation b**

- The service should introduce a system to obtain a Disclosure Scotland Protecting Vulnerable Group (PVG) update for all staff at regular intervals. This will ensure that staff remain safe to work in the service.

### Our findings

**Quality indicator 7.3 - Communication and team working**

Considerable efforts were made to promote effective communication between staff, patients, families and carers. Regular patient and staff meetings were held. All stakeholders were invited to participate in multidisciplinary team meetings and case conferences. Patients told us the information they received from staff between different shifts was not always consistent.

All staff and patients we spoke with told us the ward managers operated an open door policy. Both staff and patients could approach the manager to discuss any concerns. A range of patient meetings were held, including individual and group sessions. A patient representative attended clinical governance meetings to provide feedback to senior management. Minutes and outcomes of these meetings were recorded appropriately and shared with the relevant stakeholders.

Staff told us two team meetings were held once a month to cover both day and nightshift staff. Staff told us they were given the opportunity to contribute to the meeting’s agenda and felt that their contributions were meaningful. Minutes were made available to all staff. To encourage attendance, staff had the option to attend meetings on their days off and were paid for their time. Staff also had the opportunity to attend ‘Have your say forums’. These enabled staff to discuss the wider organisational issues and contribute new ideas about how the service was delivered. A staff representative from the service also attended national forums to provide feedback to the Priory Board.

Staff told us there were sufficient communication processes to keep them informed about their day-to-day responsibilities. This included ward handovers between shifts, and team leaders providing staff with handover sheets. Staff showed us communication books and training diaries. These included forms they signed to confirm they had received important information. Staff also had access to the organisation’s intranet and there was regular communication from senior management including newsletters, safety briefings and staff surveys.
The service was making efforts to ensure that staff at all levels had the opportunity to contribute to multidisciplinary team meetings, case conferences and patients tribunals. Representatives from the patient’s referring team were also invited to these meetings. The service had video-conferencing facilities available for stakeholders to participate remotely if required. Patients’ referring teams were updated regularly on the patient’s treatment progress and were involved in discharge planning. Care plans had also been updated with a view to improve communication and be more person-centred. All staff, including therapists and consultants, fed into the care plans to ensure that everything was recorded in one place. This allowed the named nurse to provide more comprehensive feedback to their patients.

**What needs to improve**
The service had recently asked staff to complete a staff survey. However, not all staff were aware of the findings from this survey. The service reported that it had issued the results of the survey by email, but some members of staff had chosen not to read them.

The service had made considerable effort to ensure there was effective communication between staff at all levels and the people they cared for. However, patients told us there were still inconsistencies in the communication they received from staff between different shifts, in particular about rules and expectations on the ward. Senior management agreed that more needed to be done to ensure that the approach to care and treatment was consistent across shift patterns.

- No requirements.
- No recommendations.
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

The service had a visible and supportive leadership team that was open to new ideas and change. Time and effort was invested in reviewing policies, procedures, systems and processes to identify areas for improvement. This helped to ensure that quality improvement was a core part of delivering the service.

Senior staff adopted a shared approach to quality improvement with key stakeholders that included patients, carers and staff. Professional development opportunities were available for staff, for example leading on the implementation of the ‘safeways’ initiative, audits and improvement work. We saw staff were encouraged to share their ideas for improvement with senior staff members.

Good governance structures were in place to ensure the service delivered high quality, safe, person-centred care. This included reviewing feedback from patients, families, complaints and adverse events in order to promote service change. We saw that safety and quality of care was regularly discussed at senior staff meetings.

The service was working with the Scottish Patient Safety Programme and Healthcare Improvement Scotland to develop a national policy to reduce incidents and improve observation practice in mental health services. Going forward, the service plans to involve and support staff with an interest in taking forward this improvement work.

Over the last 6 months, the service had become more ‘carer aware’. Staff had attended training about the involvement of carers in the patients’ journey and the confidentiality issues surrounding this. A carers champion had been appointed to help staff put this learning into practice.
Senior managers met with each of the ward managers every month. This was an opportunity for staff to have a reflective discussion about their experiences and practice.

The service had involved patients in staff interviews, where appropriate, over the last 2 years. The service also planned to involve patients in the delivery of training events about ‘What matters to me’. This initiative allows staff to record key personal information about patients such as habits, background, preferences and things that are important to them in order to provide personalised care and treatment.

Staff achievements were recognised by the provider in a number of ways, including the ‘Pride Awards’. This was an annual awards ceremony across the provider group of hospitals that recognised staff achievements when they had gone above and beyond in their role.

It was clear that quality improvement was a core part of the service’s aims and objectives. We saw the service’s quality improvement plan was continually monitored and updated. We also saw that the service had identified areas for improvement that we had highlighted during the inspection.

- No requirements.
- No recommendations.
Appendix 1 – Requirements and recommendations

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

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the 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>Requirements</th>
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<tr>
<td>No requirements</td>
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<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>a The service should ensure a risk assessment and management plan is put in place for patients who are out on pass and home leave (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 4.14

### Domain 7 – Workforce management and support

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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 4.24
### Recommendations carried forward from our 9–10 January 2018 inspection

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</tr>
<tr>
<td>Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.16</td>
</tr>
<tr>
<td>The service should develop suitable training for staff which will provide them with the knowledge they need to manage patients who have complex eating disorders.</td>
</tr>
<tr>
<td>Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14</td>
</tr>
</tbody>
</table>
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