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 Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
## Contents

1. A summary of our inspection  
   - Page 4

2. Progress since our last inspection  
   - Page 7

3. What we found during this inspection  
   - Page 9

**Appendix**

- Appendix 1 – Requirements and recommendations  
  - Page 24
- Appendix 2 – Grading history  
  - Page 28
- Appendix 3 – Who we are and what we do  
  - Page 29
- Appendix 4 – How our inspection process works  
  - Page 31
- Appendix 5 – Inspection process  
  - Page 33
- Appendix 6 – Terms we use in this report  
  - Page 34
1 A summary of our inspection

About the service we inspected

Kings Park Hospital is situated near Stirling in a quiet residential area close to local amenities. The hospital is part of BMI Healthcare Limited. It is a purpose built single storey building and offers inpatient and outpatient services and provides a range of private medical and surgical treatments. Onsite car parking is available.

The hospital has 21 beds in single rooms all with private en-suite facilities. Each room has a nurse-call system. Accommodation is available for patients’ relatives who may wish to stay overnight. The hospital also has:

- four outpatient consulting rooms
- two surgical operating theatres
- an imaging department, and
- a physiotherapy department.

About our inspection

This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

Grades may change after this inspection due to other regulatory activity, for example if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

We carried out an unannounced inspection to Kings Park Hospital on Monday 24 and Tuesday 25 November 2014.

The inspection team was made up of two inspectors: Winifred McLure and Karen Malloch and a public partner, Gillian Duffy. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them.

We assessed the service against five quality themes related to the Healthcare Improvement Scotland (requirements as to independent healthcare services) regulations and the National Care Standards. We also considered the Regulatory Support Assessment (RSA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: 5 - Very good
Quality Theme 1 – Quality of care and support: 3 - Adequate
Quality Theme 2 – Quality of environment: 4 - Good
Quality Theme 3 – Quality of staffing: 4 - Good
Quality Theme 4 – Quality of management and leadership: 4 - Good

The grading history for Kings Park Hospital can be found in Appendix 2 and more information about grading can be found in Appendix 4.
Before the inspection, we reviewed information about the service. We considered:

- the service self-assessment
- the service annual return
- the notifications the service has made to us
- the regulatory support assessment, and
- the findings of the last inspection.

During the inspection, we gathered information from a variety of sources. This included:

- environmental risk assessments
- information leaflets and folders
- minutes of meetings
- organisational and hospital policies and procedures
- patient care records for people who use the service
- quality and risk reports
- satisfaction questionnaires, and
- staff files and training records.

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

- a housekeeper
- four people who use the service
- the head chef
- the hospital manager
- the infection control nurse
- the maintenance manager
- reception staff
- senior registered theatre practitioners
- the hospital services manager
- theatres booking co-ordinator, and
- ward nursing staff.

We inspected the following areas:

- the reception area
- the inpatient ward
- general corridor areas
- the boiler room
- the theatre suite, and
- a sample of patient bedrooms.
What the service did well
We noted that the service:

• provided good information to people, allowing them to give informed consent about procedures or treatments that they may undertake
• had good systems and processes to manage risk within the hospital, and
• provided a high standard of care to patients.

What the service could do better
We found the service needed to improve:

• medicine management within the hospital
• Increasing staff awareness of SIGN guidelines in relation to venous thromboembolism (VTE) risk assessments, and
• staff awareness of adult protection policies and procedures.

This inspection resulted in two requirements and 13 recommendations. The requirements are linked to compliance with the Act 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.

BMI Healthcare Limited, the provider, must address the requirements and the necessary improvements made, as a matter of priority.

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

What the provider has done to meet the requirements we made at our last inspection on 16 January 2013

Requirement

The provider must put in place effective systems to audit and monitor the quality of record keeping in the service, specifically but not exclusively in relation to care records, to ensure it is in line with all relevant current legislation and best practice guidance.

Action taken

The hospital had started to use the BMI audit tracker. This document was available to all staff and the results of the audits are entered monthly and reviewed by the hospital member and reported at the clinical governance meeting. These audits are for both clinical and non-clinical departments of the hospital. **This requirement is met.**

What the service has done to meet the recommendations we made at our last inspection on 16 January 2013

Recommendation

We recommend that the provider should regularly review its participation strategy, to ensure that it remains relevant and effective. The hospital should continue to develop ways to seek the views of people who use its services, their families, staff, visiting consultants, and other people with a professional interest in the service, and use those views to influence how the service is provided.

Action taken

The participation document had been reviewed. Patient questionnaires were reviewed monthly and comments distributed to heads of department. This ensures that both positive and negative feedback was disseminated to all staff. Any improvements to the services are discussed at heads of departments meetings. A formal participation policy was being developed and will be completed soon. This is discussed under Quality Statement 2.1. **This recommendation is met.**

Recommendation

We recommend that the provider should ensure that it has a system in place to evaluate the effectiveness of the e-learning system in use within the service, and to demonstrate that staff can evidence how the learning they undertake has informed their practice.

Action taken

A ‘reflection on training document’ had been introduced for staff to reflect on the training they had done. **This recommendation is met.**

Recommendation

We recommend that the provider should develop a system of clinical supervision to allow staff to regularly review their practice and identify any areas of good practice and any areas for development.
Action taken
This is discussed under Quality Statement 3.3. This recommendation is not met.

Recommendation
We recommend that the provider should develop a system to check the quality of domestic cleaning.

Action taken
During this inspection, we looked at cleaning and infection control arrangements. Domestic cleaning schedules were in place for daily, weekly and monthly cleaning and audited every month. This recommendation is met.

Recommendation
We recommend that the provider should put systems in place to ensure that information received following criminal record checks is stored and disposed of in line with guidance from Disclosure Scotland.

Action taken
We saw staff files and they were stored centrally. Information about criminal record checks were stored on a database which included the Protecting Vulnerable Group scheme (PVG) membership number, date of check, reason for check and the decision made. This recommendation is met.

Recommendation
We recommend that the provider should ensure it receives written feedback from any visits made to assess quality within the service.

Action taken
The hospital had an internal compliance visit in April 2014. The report was detailed and concise. The feedback from the visits was good and the service provided the action plans that were developed to address areas of improvement identified by as a result of the visit. This recommendation is met.
3  What we found during this inspection

Quality Theme 0 – Quality of information

**Quality Statement 0.2**

We provide full information on the services offered to current and prospective service users. The information will help service users to decide whether our service can meet their individual needs.

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

Kings Park Hospital has many ways of telling people about the services provided including a range of information leaflets. Information was provided on specific clinical and surgical procedures that the hospital carried out, including the risks involved, possible complications and benefits.

Designated staff booked appointments and liaised with patients about their admission. Staff told us that they provided patients with the opportunity to ask any questions. Customer care was monitored through the use of questionnaires, surveys and complaints activity.

New patients were sent a booking confirmation pack and an admission letter that informed them about pre-operative procedures and confirmed costs. A ‘Preparing for your stay’ leaflet provided information on:

- what patients should bring into hospital
- how to pay for their treatment
- information on consent, and
- accommodation and visitors.

We also saw that each patient had an information folder in their room called ‘A guide to your stay’ that included details about meals, pain management, confidentiality and complaints.

Healthcare information about various parts of the service was provided on the BMI Healthcare website. Information for prospective service users included how to get to the service, procedures and treatments offered, prices and how to enquire about treatment. A helpline number was also provided for further queries.

To provide more information about the service, the hospital had also uploaded a video on social media called ‘A patients journey’. This is a short film on a patient’s experience from admission to discharge. We saw that many people had viewed this.

The hospital manager told us that information about the service could be translated into other languages if required. An audible version of the information can also be provided if requested.

We saw a consultant directory that provided information on specialties and contact details for all consultants: this was provided to GPs to assist them when making referrals or advising patients.

We looked at a patient satisfaction report from October 2014. We noted that patients were satisfied with the information the service provided them. Patients told us they had received sufficient information before being admitted to the hospital and that the information was easy to understand. One patient commented ‘I knew what to expect from start to finish and the staff are very helpful and answer any questions.’
Areas for improvement

Although we saw a range of information leaflets, the print size was smaller than the recommended size 12 font. We suggest that when information leaflets are reviewed and updated, the size of font could be increased in line with best practice. Accessibility to leaflets could also be improved if these were available to download to the website.

We read the information provided to patients and saw that patients were told that a lockable drawer was available in their room for securing valuables. However, in the bedrooms we inspected there were no lockable drawers provided. The patient information could be changed to reflect the actual arrangements at the hospital for storing patient’s valuable items.

We saw that the website contained information on how to make a complaint. However, as the provider is based in England the information reflected the arrangements there and did not make it clear what the arrangements are in Scotland. Although we saw a brief mention of Healthcare Improvement Scotland, there was no contact address or number clearly displayed for patients in BMI Healthcare hospitals in Scotland (see recommendation a).

The patient information brochure we saw in the hospital contained out-of-date information about how to complain. This should be updated to reflect Healthcare Improvement Scotland (see recommendation b).

- No requirements.

Recommendation a

- We recommend that the provider should update their website to be clear about how to make a complaint about each BMI Healthcare service in Scotland.

Recommendation b

- We recommend that the service should update the patient information brochure to include Healthcare Improvement Scotland in the complaints information. This will ensure that people who use the service, who wish to make a complaint, are aware of how they can contact Healthcare Improvement Scotland.

Quality Statement 0.4

We ensure that information held about service users is managed to ensure confidentiality and that the information is only shared with others if appropriate and with the informed consent of the service user.

Grade awarded for this statement: 5 - Very good

The service had strong systems and processes in place relating to all aspects of information management. We saw policies and procedures to guide staff in information management, in line with recommended good practice (Caldicott Principles). Regular audits were checked if confidentiality was being maintained and the results showed that staff were following correct procedures. All incidents in relation to breaches in confidentiality were part of the reporting requirements and we noted there had been no breaches reported in the past 6 months.

The service provided patients with information about confidentiality, and we saw signed consent forms completed by patients agreeing to their care notes being available in their room during their stay.
The service’s electronic information systems were password protected and passwords were changed regularly. We saw that computers were placed in areas that ensured screens could not be observed by unauthorised people.

The printers were kept in secure areas and this ensured that private information was accessed only by authorised staff. We saw large bins for destruction of confidential waste and staff confirmed that they used these for all sensitive documents.

Private areas were accessed using key pads and codes were regularly changed as a precaution.

Staff told us that they had received training on confidentiality and data protection and they were clear about their responsibility in relation to this. We saw how staff respected patients privacy and dignity during the inspection.

Areas for improvement

The hospital reception is a large open area and we saw that this can often be busy with people waiting for appointments and admission to the hospital. We observed that privacy and confidentiality was difficult to maintain, particularly when staff were taking phone calls. The service could review how best to manage sensitive calls in a way that maintains confidentiality.

Although staff understood and practiced confidentiality, some staff did not know what the Caldicott Principles were. They are the 6 principles for NHS bodies and those contracting with the NHS to adhere in order to protect patient information and confidentiality. The Caldicott Guardian is the person appointed to ensure that the principles of patient confidentiality are adhered to. We saw that a corporate bulletin had been circulated to staff in October 2014 about the Caldicott Principles and the role of the Caldicott Guardian. We noted that the hospital had set a deadline for all staff to complete training and understand the caldicott principles and the role of the Caldicott Guardian by 30 November 2014. We will review this on a future inspection.

- No requirements.
- No recommendations.

Quality Theme 1 – Quality of care and support

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: 3 - Adequate

As Kings Park Hospital does not have an onsite pharmacy, medication was provided through a service level agreement (SLA) with NHS Forth Valley. A pharmacist visits the wards three times a week and checks the inpatient prescription charts and offers advice and answers any queries that the staff may have. We saw evidence of medicines management policies and of medication error reporting systems.
We were told that any medication errors were discussed at clinical governance meetings and a review of the minutes confirmed this. All the staff spoken with during the inspection were able to tell us the procedure they would follow if there was a medication error.

All registered nurses had undertaken medication training which included competencies to be demonstrated and an initial period of supervised practice. Registered nurses then complete an online module every year.

We looked at three prescription sheets during the inspection. We found that all the prescriptions had:

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

We also looked at the prescription recording sheets that corresponded to these prescriptions. These had all been completed fully.

We were told that people who needed to take regular medication while they were in the hospital were advised to bring their own medication with them. We saw this could then be prescribed for them by the doctor. We saw that there was guidance in place about what medications people should stop taking before undergoing procedures in the hospital. We saw that the medication people normally took was checked at their pre-admission assessment.

The service had a nominated accountable officer for controlled drugs. The service was also inducting a new clinical pharmacist and a pharmacy technician to bring the pharmacy service in house and to ensure that ordering, prescribing, administration and storage and disposal of medication was aligned fully to corporate policy.

**Areas for improvement**

During the inspection, it was difficult to assess who had overall responsibility for medicines management within the hospital. There were no medicines management subgroup meetings, routine audits for controlled drugs, checks of the inpatient prescription charts were not being carried out for all patients and prescribing practices were not being regularly monitored. It is important that there is a system in place to ensure that prescribing practices in the hospital are safe, secure and robust (see requirements 1 and 2 and recommendation c).

Although systems were in place for patients to bring in their own medications, there was no formal process of medicines reconciliation. Medicines reconciliation is a key step to ensuring that patients are prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and that avoidable harm from medicines is reduced. The Scottish Government issued medicines reconciliation guidance (SGHD/CMO(2013/18) in September 2013. The service should adopt systems and processes to ensure medicines reconciliation is undertaken and monitored (see recommendation d).

Although we saw that staff competency to administer drugs was assessed online annually, they do not undergo any further observations of their practice when they are administering medication. It is good practice to periodically observe staff when administering medication to ensure they are doing so safely.
Requirement 1 – Timescale: by 4 March 2015

■ The provider must identify who has overall responsibility for medicines management within the hospital.

Requirement 2 – Timescale: by 4 March 2015

■ The provider must implement a system for the overall monitoring of medications management which includes a programme of regular audit.

Recommendation c

■ We recommend that the service should restart regular meetings of the medicines management subgroup.

Recommendation d

■ We recommend that the service should develop and implement a policy clearly outlining the medicines reconciliation process, including roles and responsibilities of key professionals in medicines reconciliation. The policy should state that two or more sources of information, one of which should be the patient and carer and their own medicines supply, are to be used on admission to obtain an up-to-date and accurate medication. This should be recorded in the patient care record.

Quality Statement 1.6

We ensure that there is an appropriate risk management system in place, which covers the care, support and treatment delivered within our service and, that it promotes/maintains the personal safety and security of service users and staff.

Grade awarded for this statement: 4 - Good

Staff and visitors to the hospital used a sign-in and sign-out system at the front reception. This helped to make sure that the hospital is secure.

The service had a clear organisational structure in place. Each department had health and safety representatives who attended health and safety committee meetings which were held every three months. Mandatory training was provided for staff online via BMI Learn and included fire safety, health and safety, manual handling, and infection control. This was monitored closely by senior staff to ensure compliance with some staff trained to Institute of Safety and Health (IOSH) managing safely level.

We spoke with the maintenance manager who showed us service records for clinical and non-clinical equipment, including equipment serviced by outside contractors. We were also shown the process for reporting and recording issues with equipment and how that was dealt with every day. We saw a computer based maintenance programme was used, which generated work orders and maintenance requests. We saw that clinical equipment was serviced by medical physics with specialised servicing and repairs were carried out by manufacturers. We saw evidence of environmental risk assessments including, fire and water assessments and evidence of fire education and drills being carried out twice a year.

We saw Control of Substances Hazardous to Health (COSHH) information and risk assessments were in place and were managed by each department. There was a system in place to ensure staff had read and signed for this information.
During the inspection, we checked four patient care records and found good standards of record-keeping. Entries were signed, dated and the time was recorded. There were different pathway records held for patients depending on procedures and length of stay. Essential details such as next of kin and consent to treatment were also recorded. The consent form was signed by the patient and the surgeon and listed the potential risks of the operation or procedure. We saw that individual risk assessments were recorded in the patient care record. These included:

- falls
- moving and handling
- pressure ulcer
- malnutrition, and
- use of bedrails.

We also saw risk assessments for VTE and a theatre safety checklist.

The World Health Organization (WHO) issued guidelines called ‘Safe Surgery Saves Lives’. These detail best practice for performing surgery in a safe way. We followed a patient’s journey from the ward to theatre and the recovery room. We saw staff carried out a checklist to confirm the patient’s identity, date of birth, site of operation and other key information at each handover point. This is in line with the WHO Safe Surgery guidelines.

Another recommendation from WHO is for staff in theatres to have a timeout or surgical pause before they start the surgery. A surgical pause is when staff make a final check that they have the correct patient, the correct equipment and are about to perform the correct procedure before starting the surgery. We saw that a surgical pause took place involving all relevant staff and this was recorded on the surgical safety checklist.

During surgery, staff in the theatre should count all the swabs, needles and instruments that are used. This means that they can then count them at the end of the surgery to make sure nothing has been left in the patient. We saw that staff did this and used a whiteboard to keep a running total during the operation. This allows staff to make an accurate check when the operation is finished and this was recorded in the patient care plan.

The service used a paper system for reporting all incidents, both clinical and non-clinical; this information was then put into the electronic system called Sentinel. The electronic system can generate reports based on any number of the criteria recorded and this is then reported back to the relevant areas and staff. The hospital also had a risk register in place.

**Areas for improvement**

As BMI Healthcare is an English organisation, some documents referred to English guidelines such as National Institute for Health and Care Excellence (NICE) rather than Scottish Intercollegiate Guidelines Network (SIGN). Senior staff acknowledged this and they are in the process of seeking a solution.

In discussions with staff, it became clear that they were not fully aware of the SIGN guideline relating to VTE. Although the risk assessment was quite comprehensive, there was no guidance given on the treatment options to be used based on the outcome of the risk assessment (see recommendation e).

Although the service has an adult protection policy which does reflect the requirement of Scottish legislation, it was more reflective of the arrangements in England. We spoke with
staff and found that awareness and knowledge of adult protection policies and procedures were limited (see recommendation f).

The anaesthetic machines are checked daily to make sure they were safe, in good working order and this is recorded in the log book provided. Monthly and weekly maintenance checks are also carried out, such as filter and soda lime changes. However, these were not fully recorded in the book provided. A detailed record of when these checks are due and completed should be kept. Also, serial numbers of circuits should be logged in the books provided when they are changed (see recommendation g).

- No requirements.

**Recommendation e**

- We recommend that the service should ensure that staff are aware of Scottish guidelines in relation to VTE and associated risk assessment.

**Recommendation f**

- We recommend that the service should deliver additional training on adult support and protection to ensure staff are aware of their roles and responsibility in relation to adult protection policies and procedures.

**Recommendation g**

- We recommend that the service should keep detailed records of all the checks and maintenance of the anaesthetic machines along with the serial numbers of circuits as they are replaced.

**Quality Theme 2 – Quality of environment**

**Quality Statement 2.1**

We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

**Grade awarded for this statement: 4 - Good**

The service sought patients views about the service by using a detailed questionnaire and a shorter postcard-style comment card.

The questionnaire covered all aspects of service delivery and included some questions about the quality of accommodation. Patients were asked to grade each area from poor to excellent and could add specific comments on areas that they felt could be improved. Patients were asked to comment on:

- noise levels
- cleanliness
- signage
- facilities, and
- overall quality of accommodation.

All the results from the questionnaire were put in a report that was used to monitor how the hospital was doing and was used to benchmark against other BMI hospitals. Feedback from
patients was used to drive improvements. The hospital manager told us that a replacement programme was in place for televisions as patients had commented that these required to be updated. A rolling programme of refurbishment was under way following comments that the hospital looked ‘tired’.

Patients could also raise any concerns about the environment directly with staff or through the complaints procedure. Patients also told us that they were aware of how to raise any concerns.

The provider’s internal quality assurance system included an annual visit from senior management and peers from other services. We saw the report from the last visit in April 2014. We noted that during these visits, patients were interviewed and asked to comment on the environment.

**Area for improvement**

The service had scheduled patient focus meetings, but no patients attended. The hospital manager told us another meeting was planned in December 2014. The hospital manager told us that the hospital was also looking at ways to improve feedback at a local level. We looked for a patient participation policy and were informed that the corporate policy document was under review and that a local policy was at the development stage. We saw that there were some opportunities for user participation but this was only mentioned briefly in the clinical governance policy (see recommendation h).

- No requirements.

**Recommendation h**

- We recommend that the service should produce a formal patient participation policy to improve opportunities to engage with patients and relatives, and gather feedback for service development.

**Quality Statement 2.4**

We ensure that our infection prevention and control policy and practices, including decontamination, are in line with current legislation and best practice (where appropriate Scottish legislation).

**Grade awarded for this statement: 4 - Good**

The service had systems and processes in place to prevent and manage infection. We saw that the hospital environment was clean and that housekeeping staff had schedules in place for cleaning tasks and that these were up to date and audited every month. Patients reported high levels of satisfaction with the standard of cleanliness.

The service had an infection control co-ordinator. Their role included the provision of staff support and education. Monitoring of infection control was through regular audits, including:

- sharps
- waste management, and
- the environment.

A hospital infection control committee was in place that included link practitioners from wards and departments, a decontamination lead and a consultant microbiologist. We saw the
minutes from these meetings which confirmed that, environmental issues, monthly infection rates, training, audit results, use of antibiotics, and policies and procedures were discussed. A regional infection prevention and control adviser provided additional support and guidance. We also saw the annual infection prevention and control work plan. This was a live document and highlighted infection control priorities and included timescales to be met. We saw a range of policies and procedures guiding infection prevention and control practices were available for staff on the service’s intranet and in hard copy.

The service is planning to implement care bundles developed by Health Protection Scotland (HPS) and we will monitor progress with their implementation at future inspections. These provide a set of practices to improve care in areas, such as hand hygiene and preventing surgical site infections.

We saw many leaflets and information on infections for patients. The service had used antibiotic awareness week to provide health promotion through posters and leaflets to patients and staff on the use and over use of antibiotics.

Staff told us that they received training on infection control, and we saw that there had been recent training on Ebola and cleaning blood spillages. The infection control and prevention lead had undertaken the cleanliness champion’s course and had found this extremely valuable.

Flexible endoscopes are used by doctors to look inside people using a small camera. Flexible endoscopes need to be properly cleaned after use before they are used again. In Kings Park Hospital, the decontamination of flexible endoscopes is carried out in a small room within the theatre suite. The decontamination room has:

- a set-down area for contaminated endoscopes
- an automatic leak test and channel flushing unit
- a sink for leak testing and manual cleaning of endoscopes
- a sink for rinsing endoscopes
- a set-down area for rinsed endoscopes
- a clinical hand wash basin (not compliant), and
- a clinical waste bin.

The endoscope is then transferred to a room which contains an automatic endoscope washer disinfector fed with filtered mains water. The endoscope is placed in this washer which has a pass through to another room where it is removed once cleaned. There is a high efficiency particulate air (HEPA) endoscope storage cabinet in this room. This provides up to 72 hours of storage for clean and disinfected endoscopes.

It is important a system is in place to track endoscopes to ensure that they have been through the decontamination process properly. Both the endoscope washer disinfector and the storage cabinet in Kings Park Hospital have the facility for electronic tracking and monitoring. The endoscope washer disinfector prints out a small certificate confirming that each endoscope has been through the correct cleaning process. The certificate is attached to both the theatre records and the patient healthcare record. Records showed that the endoscope washer disinfector had been installed correctly. At the time of inspection, the washer disinfector was not being used. Contaminated mains water had blocked the filters and these had been ordered and were waiting to be replaced. All endoscopy patients were being sent to another facility. A manual traceability system was in place. If a problem is
identified with a particular endoscope, the system is designed to trace all patients connected to that endoscope.

One of the main risks during the decontamination process is cross-contamination between clean and contaminated endoscopes. The decontamination process at Kings Park Hospital uses a pass through system. This means that the probability of a contaminated endoscope and a clean endoscope being cleaned at the same time is low. All other surgical instruments are decontaminated and sterilised at an off-site facility.

The hospital had replaced the hand wash basins in the consulting rooms as these did not meet current guidance on the design for clinical hand washing units. An internal audit had identified sinks in many areas that needed to be replaced.

Every year, occupational health offers staff immunisation for Hepatitis B and the flu vaccine.

Areas for improvement
The care bundles for hand hygiene and surgical site infections had not started and should be implemented to improve patient care. The infection control policies, procedures and guidance refer to English guidance and legislation. We discussed this with the hospital manager who told us that this was being addressed corporately and that new policies, procedures and literature were being developed to reflect Scottish guidance and legislation (see recommendation i).

The program for replacing sinks should continue as planned, informed by the outcome of the risk assessments (see recommendation j).

- No requirements.

Recommendation i
- We recommend that the service should ensure that infection control policies and procedures refer to Scottish guidance and legislation.

Recommendation j
- We recommend the service should undertake a risk assessment of clinical hand wash basins that are not compliant with current standards and identify priority for replacement as part of the ongoing programme.

Quality Theme 3 – Quality of staffing

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: 4 - Good
We found that Kings Park Hospital had good systems in place to involve people who use the service in assessing and improving the quality of staffing provided.

We saw that staff actively sought and listened to the views of people who use the service and valued their opinions. When we spoke with people who were using the service, they confirmed this.
Throughout the hospital, we found questionnaires that patients could complete to give feedback on their experience; this included an area to comment on staff. We saw that these were reviewed and results of the feedback were displayed throughout the hospital. All patients we spoke with said they were treated with dignity and respect at all times.

A complaints policy was in place and information about how to make a complaint was available. Any complaints against staff were taken seriously. If required, support and learning needs are identified and an action plan is put into place.

**Areas for improvement**

There was no formal policy on how to obtain feedback from patients and how to respond to it. We were told that the service was developing a formal policy which could outline this activity clearly and benchmark expectations so that it could be measured for effectiveness.

- No requirements.
- No recommendations.

**Quality Statement 3.3**

Have a professional, trained & motivated workforce which operates to National Care Standards, legislation & best practice.

**Grade awarded for this statement: 4 - Good**

Within the last year, changes had taken place within the hospital management and staffing structure. A new hospital manager had been appointed and services were being aligned with a larger sister hospital to provide support and a more streamlined service.

The service had access to the corporate BMI Healthcare computer-based training system, BMI Learn. This system sets out all the mandatory training for employees based on their role in the hospital. Mandatory training includes:

- adult basic life support
- fire safety
- infection prevention and control
- moving and handling, and
- equality and diversity.

It also monitors when a particular module was last completed and reminds staff and managers when refresher training is due. A reflection on training document had been introduced. This allows the management at the hospital to evaluate the effectiveness of the e-learning system and gives staff the opportunity to demonstrate how the learning they have undertaken has informed their practice.

BMI Learn also supported staff development. As well as the mandatory modules, staff could apply through their line manager to have any module in the system added to their profile for them to complete as part of their continuing professional development (CPD) or in preparation for applying for a new or more senior role in the organisation. There was also a facility to record any CPD training that had been completed out with the BMI Learn system. This gave the service comprehensive development records for each employee. Yearly appraisals were carried out which monitor staff performance. Staff also take on other
responsibilities for specific areas, such as blood transfusion. They then provide help for staff and act as a resource and organise and provide practical training sessions to complement online modules.

The electronic system provided management with an overview of the training that had been completed in each year, and how much was still to be completed. This was a useful tool to help ensure that all staff completed the training required within timeframes; this was being monitored at both a corporate and local level.

We saw:

- an induction package was in place with a period of probation for new staff
- staff files were now stored centrally and were being scanned online, and
- that systems were in place to ensure criminal record checks were stored and disposed of in line with Disclosure Scotland guidance.

Nurses’ and allied health professions’ (AHPs) registrations were checked and recorded using online verification systems and a system was in place to check these annually.

We spoke with some patients during the inspection and they told us the staff:

- ‘Were fantastic, very attentive, very professional, friendly and very helpful.’
- ‘Polite, professional and very helpful.’
- ‘Have been great – everyone I have seen.’

We also spoke with staff to find out their views of working in the hospital. Staff reported that Kings Park Hospital was a good place to work and there was a strong teamwork ethos in place. In particular, they reported good working relationships across the multidisciplinary team. All staff we spoke with felt empowered to challenge a colleague’s behaviour or practice if they felt it would put a patient at risk.

Area for improvement

Although there was a system for appraisals to take place via BMI Learn, nursing staff told us that they had not had an appraisal for some time. Senior staff and management were aware of this and were in the process of rolling out a new system. Development of a system of clinical supervision had not yet been completed (see recommendation k).

Staff are aware of the NHS Education for Scotland (NES) Core Competencies for Anaesthetic Assistants, but they have not been completed. The Association of Anaesthetists of Great Britain and Ireland provide the following statement on trained assistance for the anaesthetist:

‘The Anaesthetic Assistant role should be undertaken by a registered practitioner who has achieved either those competencies specified in the curriculum of the College of Operating Department Practitioners or those specified in the NHS Education for Scotland Core Competences for Anaesthetic Assistant document.’

It is therefore essential that those undertaking the anaesthetic assistant’s role have completed the necessary competencies (see recommendation l).

Recommendations k

- The service should ensure that all staff have an annual appraisal in line with BMI policy. The service should also develop a system of clinical supervision to allow
staff to regularly review their practice and identify any areas of good practice and any areas for development.

**Recommendation I**

- The service should make sure that all staff undertaking the role of anaesthetic assistant have achieved the NES ‘Core Competencies for Anaesthetic’s Assistants’.

**Quality Theme 4 – Quality of management and leadership**

**Quality Statement 4.2**

*Involve the workforce in determining the direction & future objectives of the service.*

**Grade awarded for this statement: 4 - Good**

We saw that regular meetings were held with staff to discuss day-to-day business, but also to receive feedback from staff.

The hospital manager meets with the senior management team daily to ensure effective communication and to discuss the priorities for the day. This meeting includes each department in the hospital. Senior staff undertake daily leadership walk rounds, attend business development days and contribute to business development and direction of the service.

There is currently a BMI Healthcare – wide program which is looking at ways to improve efficiency and effectiveness across all departments. Staff participation was an essential part to this exercise. We saw that staff forums were regularly held and staff were encouraged to attend and contribute. A notice board provided information and reports for staff.

We spoke with staff who told us that the current BMI Healthcare – wide program looking at ways to improve efficiency and effectiveness has resulted in Kings Park hospital being closed some days, depending on the number of patients. As a result of this some staff are not always able to work their contracted hours. This means they can either owe the hospital hours, or work at another BMI hospital. Staff said that while they felt they were being supported and informed regarding changes, this has had a negative impact on morale and staff confidence.

BMI undertakes an annual ‘BMI Say’ survey and the manager told us that this information is used to direct service development. We saw that the survey results from April 2014 and this showed generally positive feedback from staff about their employment with BMI.

**Areas for development**

A recent training needs analysis for staff had not been completed. This would be useful to identify staff training needs and to develop leadership opportunities to ensure staff progression within the organisation.

- No requirements.
- No recommendations
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: 4 - Good

We found that the service has good quality assurance systems and processes. A corporate strategic plan was in place that set the direction of the service for the next 5 years. A clinical governance policy provided the framework for setting standards, monitoring quality and ensuring continuous improvement. We saw the service used a variety of ways to measure how the service was performing and how the service could be improved. These included various patient satisfaction surveys and a catering survey, audits, staff survey, accidents and incident reporting, and infection rate monitoring. Internal visits from head office were undertaken every year to review how the service was performing.

A clinical governance committee was in place at the hospital and this had a standing agenda that included reports from sub groups, meetings and forums, including:

- infection prevention and control
- radiation
- transfusion
- medicines management, and
- health and safety.

Other issues tabled at the meeting included accidents and incidents, complaints, staff training and a review of the risk register. All information was analysed for trends, and actions were agreed and planned. The hospital manager reported all quality activities monthly to the regional clinical assurance committee and provided a detailed action plan.

To further ensure that all hospitals learn from incidents, a ‘lessons learned’ initiative had been implemented corporately and provided the opportunity for each hospital to learn from incidents and accidents at other sites. A monthly clinical governance group bulletin was circulated to all hospitals and this included incident outcomes, information and education. In response to this, actions identified were completed by a deadline and head office monitored each service’s compliance.

The service’s medical advisory committee had a nominated member from each clinical specialty. This committee had a particular focus on clinicians’ practice. We saw minutes of a range of meetings which contained reviews, actions and confirmation that agreed tasks had been completed.

Staff we spoke with were aware of responsibilities for having a programme of quality assurance, and policies were up-to-date and accessible on the intranet. We noted examples of audit activity for clinical care medical notes, health and safety, and infection prevention and control. We viewed audits and each audit had an action plan developed in response to any issues raised.

We saw a complaints log and noted that the amount of complaints received was low and that complaints were responded to in line with the service’s policy.

Area for improvement

We noted that the medicines management subgroup had not met for a period of time. While the hospital was in transition with pharmacy service, medicines management monitoring systems were not effectively in place (see requirements 1 and 2 and recommendation c).
Lessons learned had yet to be fully implemented for staff. We saw this as a very positive development that will provide shared learning and useful reflection on practice. We noted that best practice guidance in relation to bulletins was sourced in England (see recommendation m).

Although a schedule was in place for audits and we saw how these were reported through clinical governance, staff we spoke with were not aware of audit outcomes. The hospital manager told us that this had been identified and they planned to display audit results on staff information boards.

■ No requirements.

**Recommendation m**

■ We recommend that the service’s policies and procedures should reflect Scottish best practice guidelines and standards.
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.

<table>
<thead>
<tr>
<th>Quality Statement 0.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td><strong>We recommend that the service should:</strong></td>
</tr>
<tr>
<td>a</td>
</tr>
<tr>
<td>update their website to be clear about how to make a complaint about each BMI Healthcare service in Scotland (see page 10).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 9.2 – Express your views)</td>
</tr>
<tr>
<td>b</td>
</tr>
<tr>
<td>update the patient information brochure to include Healthcare Improvement Scotland in the complaints information. This will ensure that people who use the service, who wish to make a complaint, are aware of how they can contact Healthcare Improvement Scotland (see page 10).</td>
</tr>
<tr>
<td>National Care Standards – Independent Hospitals (Standard 9.2 – Express your views)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Statement 1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirement</strong></td>
</tr>
<tr>
<td>The provider must:</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>identify who has overall responsibility for medicines management within the hospital (see page 13).</td>
</tr>
<tr>
<td>Timescale – by 4 March 2015</td>
</tr>
<tr>
<td>Regulation 3 (d) (iv)</td>
</tr>
<tr>
<td>The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011</td>
</tr>
</tbody>
</table>
2. Implement a system for the overall monitoring of medications management which includes a programme of regular audit (see page 13).

Timescale – by 4 March 2015

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

**Recommendation**

**We recommend that the service should:**

**c.** Restart regular meetings of the medicines management subgroup (see page 13).

National Care Standards – Independent Hospitals (Standard 20.0 – Medicines management)

**d.** Develop and implement a policy clearly outlining the medicines reconciliation process, including roles and responsibilities of key professionals in medicines reconciliation. The policy should state that two or more sources of information, one of which should be the patient and carer and their own medicines supply, are to be used on admission to obtain an up-to-date and accurate medication. This should be recorded in the patient care record (see page 13).

National Care Standards – Independent Hospitals (Standard 20.0 – Medicines management)

**Quality Statement 1.6**

**Requirements**

None

**Recommendations**

**We recommend that the service should:**

**e.** Ensure that staff are aware of Scottish guidelines in relation to VTE and associated risk assessment (see page 15).

National Care Standards – Independent Hospitals (Standard 12.1 – Clinical Effectiveness)

**f.** Deliver additional training on adult support and protection to ensure staff are aware of their roles and responsibility in relation to adult protection policies and procedures (see page 15).

National Care Standards – Independent Hospitals (Standard 12.1 – Clinical Effectiveness)

**g.** Keep detailed records of all the checks and maintenance of the anaesthetic machines along with the serial numbers of circuits as they are replaced (see page 15).

National Care Standards – Independent Hospitals (Standard 15.1 – Your environment)
### Quality Statement 2.1

**Requirement**

None

**Recommendations**

*We recommend that the service should:*

- **h** produce a formal patient participation policy to improve opportunities to engage with patients and relatives, and gather feedback for service development. (see page 16).

  National Care Standards – Independent Hospitals (Standard 9.1 and 9.7 – Expressing your views)

### Quality Statement 2.4

**Requirements**

None

**Recommendations**

*We recommend that the service should:*

- **i** ensure that infection control policies and procedures refer to Scottish guidance and legislation (see page 18).

  National Care Standards – Independent Hospitals (Standard 12.1 – Clinical Effectiveness)

- **j** undertake a risk assessment of clinical hand wash basins that are not compliant with current standards and identify priority for replacement as part of the ongoing programme (see page 18).

  National Care Standards – Independent Hospitals (Standard 13.8 – Prevention of infection)

### Quality Statement 3.3

**Requirement**

None

**Recommendations**

*We recommend that the service should:*

- **k** ensure that all staff have an annual appraisal in line with BMI policy. The service should also develop a system of clinical supervision to allow staff to regularly review their practice and identify any areas of good practice and any areas for development (see page 20).
National Care Standards – Independent Hospitals (Standard 10.8 – Staff)

I make sure that all staff undertaking the role of anaesthetic assistant have achieved the
NES ‘Core Competencies for Anaesthetic’s Assistants’ (see page 21).

National Care Standards – Independent Hospitals (Standard 10.10 – Staff)

Quality Statement 4.4

<table>
<thead>
<tr>
<th>Requirement</th>
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<tbody>
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<td>None</td>
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<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>We recommend that:</td>
</tr>
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</table>

I the service’s policies and procedures should reflect Scottish best practice guidelines and standards (see page 23).

National Care Standards – Independent Hospitals (Standard 12.1 – Clinical Effectiveness)
## Appendix 2 – Grading history

<table>
<thead>
<tr>
<th>Inspection date</th>
<th>Quality of information</th>
<th>Quality of care and support</th>
<th>Quality of environment</th>
<th>Quality of staffing</th>
<th>Quality of management and leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/10/2011</td>
<td>Not assessed</td>
<td>2 - Weak</td>
<td>3 - Adequate</td>
<td>3 - Adequate</td>
<td>Not assessed</td>
</tr>
<tr>
<td>16/01/2013</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>5 - Very good</td>
<td>4 - Good</td>
</tr>
</tbody>
</table>
Appendix 3 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service. The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and in a range of formats on request), and
- listen to your concerns and use them to inform our inspections.
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service. Our contact details are:

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

Telephone: 0131 623 4300

Email: hcis.chiefinspector@nhs.net
Appendix 4 – How our inspection process works

Inspection is part of the regulatory process.

Each independent healthcare service completes an online self-assessment and provides supporting evidence. The self-assessment focuses on five quality themes:

- **Quality Theme 0 – Quality of information**: this is how the service looks after information and manages record-keeping safely. It also includes information given to people to allow them to decide whether to use the service and if it meets their needs.
- **Quality Theme 1 – Quality of care and support**: how the service meets the needs of each individual in its care.
- **Quality Theme 2 – Quality of environment**: the environment within the service.
- **Quality Theme 3 – Quality of staffing**: the quality of the care staff, including their qualifications and training.
- **Quality Theme 4 – Quality of management and leadership**: how the service is managed and how it develops to meet the needs of the people it cares for.

We assess performance by considering the self-assessment, complaints, notifications of events and any enforcement activity. We inspect the service to validate this information and discuss related issues.

The complete inspection process is described in Appendix 5.

**Types of inspections**

Inspections may be announced or unannounced and will involve physical inspection of the clinical areas, and interviews with staff and patients. We will publish a written report 8 weeks after the inspection.

- **Announced inspection**: the service provider will be given at least 4 weeks’ notice of the inspection by letter or email.
- **Unannounced inspection**: the service provider will not be given any advance warning of the inspection.

**Grading**

We grade each service under quality themes and quality statements. We may not assess all quality themes and quality statements.

We grade each heading as follows:

![Grading Scale](image)

We do not give one overall grade for an inspection.

The quality theme grade is calculated by adding together the grades of each quality statement under the quality theme. Once added together, this number is then divided by the number of statements.
For example:

**Quality Theme 1 – Quality of care and support: 4 - Good**

Quality Statement 1.1 – 3 - Adequate
Quality Statement 1.2 – 5 - Very good
Quality Statement 1.5 – 5 - Very good

Add the grades of each quality statement together, making 13. This is then divided by the number of quality statements (there are 3 quality statements), making 4.3. This is rounded down to 4, giving the overall quality theme a grade of 4 - Good.

However, if any quality statement is graded as 1 or 2, then the entire quality theme is graded as 1 or 2 regardless of the grades for the other statements.

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare provider in relation to the implementation of the improvement action plan. Healthcare Improvement Scotland will request an updated action plan 16 weeks after the initial inspection. The inspection team will review the action plan when it is returned and decide if follow up activity is required. The nature of the follow-up activity will be determined by the nature of the risk presented and may involve one or more of the following elements:

- a planned announced or unannounced inspection
- a planned targeted announced or unannounced follow-up inspection looking at specific areas of concern
- a meeting (either face to face or via telephone/video conference)
- a written submission by the service provider on progress with supporting documented evidence, or
- another intervention deemed appropriate by the inspection team based on the findings of the initial inspection.

A report or letter may be produced depending on the style and findings of the follow-up activity.

More information about Healthcare Improvement Scotland, our inspections and methodology can be found at:

Appendix 5 – Inspection process

We follow a number of stages in our inspection process.

**Before inspection**

The independent healthcare service undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help inform and prepare for on-site inspections.

**During inspection**

We arrive at the service and undertake physical inspection.

We have discussions with senior staff and/or operational staff, people who use the service and their carers.

We give feedback to the service’s senior staff.

We undertake further inspection of services if significant concern is identified.

**After inspection**

We publish reports for patients and the public based on what we find during inspections. Healthcare staff can use our reports to find out what other services do well and use this information to help make improvements. Our reports are available on our website at www.healthcareimprovementscotland.org

We require services to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.
# Appendix 6 – Terms we use in this report

## Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
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<tbody>
<tr>
<td><strong>provider</strong></td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td><strong>service</strong></td>
<td>A service is the place where healthcare is delivered by a provider. Regulated healthcare services must be registered with Healthcare Improvement Scotland.</td>
</tr>
</tbody>
</table>
We can also provide this information:

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