Unannounced Inspection Report: Independent Healthcare

Spire Murrayfield Hospital | Spire Healthcare Ltd | Edinburgh
19–20 August 2014
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  & 4  
2  Progress since our last inspection  & 7  
3  What we found during this inspection  & 9  

Appendix 1 – Requirements and recommendations & 24  
Appendix 2 – Grading history & 27  
Appendix 3 – Who we are and what we do & 28  
Appendix 4 – How our inspection process works & 30  
Appendix 5 – Inspection process & 32  
Appendix 6 – Terms we use in this report & 33
1 A summary of our inspection

About the service we inspected

Spire Murrayfield Hospital is registered with Healthcare Improvement Scotland as an independent hospital to provide medical and surgical inpatient and outpatient services to adults and children.

The hospital is part of Spire Healthcare Ltd, the UK-wide independent healthcare group. The service provides a range of medical and surgical services, including treatments for cancer.

The hospital has 70 inpatient beds divided into two wards. The ground floor ward is used for patients who need more complex surgery. The first floor ward is used for day care and short-stay treatments. The patient rooms are all single rooms with en-suite shower or bath facilities. A two-bedded high dependency unit (HDU) is also available for patients who need a higher level of care.

Spire Murrayfield Hospital is situated in the Murrayfield area of Edinburgh close to public transport services. The hospital is set in pleasant grounds and car parking is available.

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 Spire Murrayfield Hospital Tuesday 19 and Wednesday 20 August 2014.

The inspection team was made up of two inspectors: Sarah Gill and Winifred McLure, and a public partner, Ken Barker. 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: 4 - Good
Quality Theme 1 – Quality of care and support: 4 - Good
Quality Theme 2 – Quality of environment: 4 - Good
Quality Theme 3 – Quality of staffing: 5 - Very good
Quality Theme 4 – Quality of management and leadership: 5 - Very good

The grading history for Spire Murrayfield 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’s self-assessment
- the service’s annual return
- notifications the service has made to us, and
- findings of the previous inspection (23 October 2013).

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

- results of the inpatient questionnaire
- information leaflets about the hospital’s services
- four patient care records (to check risk assessment, consent forms and theatre checks)
- medication systems
- various policies and procedures
- the equipment log and maintenance checks
- agreements with external companies to carry out radiation protection checks
- theatre cleaning records
- four staff files
- staff rotas for the last 2 weeks (ground floor ward)
- induction framework
- training plan
- registration checks for all staff groups
- complaints log
- accidents and incidents log
- clinical governance systems
- audit records, and
- minutes of clinical governance meetings and clinical effectiveness meetings.

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

- six patients
- the hospital director
- the lead nurse for the hospital
- the administration manager
- the management support and complaints manager
- the human resources and training co-ordinator
- the head of sterile services department
- the theatre manager
- four staff nurses
- the nursing services manager,
- the clinical effectiveness lead, and
- the hotel services manager.
During the inspection, we visited the following areas:

- Beechwood House (outpatient department)
- first floor ward
- ground floor ward
- main building (consulting rooms and oncology suite), and
- theatres.

**What the service does well**
We noted areas where the service was performing well.

- There was a strong management team in place who were committed to improving quality assurance systems and providing a high quality service to patients.
- There were very good systems to support staff training.

**What the service could do better**
We did find that improvement is needed in the following areas.

- Stand-alone heaters must only be used if a risk assessment has been carried out to ensure that it is safe for each patient.
- Some aspects to allow patients to provide feedback could be strengthened, such as involving them in the quality of information supplied.
- Improve record-keeping for patients’ own medication, theatre counts and equipment checks.
- Ensure that all incidents are recorded including ‘near misses’ to inform learning points.

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

Spire Healthcare Ltd, the provider, must address the requirement and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Spire Murrayfield Hospital for their assistance during the inspection.
2 Progress since our last inspection
What the service has done to meet the recommendations we made at our last inspection on 23 October 2013

Recommendation

*We recommend that the service should ensure that all information given to patients using the service has the correct contact details for Healthcare Improvement Scotland. This will allow people to make complaints to Healthcare Improvement Scotland if they want to.*

Action taken

Although the ‘Please tell us’ leaflet had been updated with the correct address for Healthcare Improvement Scotland, there were still leaflets in areas of the hospital with the wrong address. Further work needs to be carried out to ensure the updated leaflets are in place in all areas of the hospital. We have looked at this again under Quality Statement 0.2. **This recommendation is not met** (see recommendation a).

Recommendation

*We recommend that the service should ensure that, when theatre staff are doing the surgical pause, there is clear leadership and all relevant staff are involved.*

Action taken

We observed this during the inspection and theatre check records also provided evidence of this being carried out. **This recommendation is met.**

Recommendation

*We recommend that the service should ensure that during every operation staff write the patient’s name, date of birth, allergies and the initial swab, blade and needle count on the theatre whiteboard. This will allow staff to make an accurate count of what equipment should be left at the end of the surgery.*

Action taken

We observed this during the inspection and theatre check records also provided evidence of this being carried out. **This recommendation is met.**

Recommendation

*We recommend that the service should ensure that all staff check the list of equipment when they are counting equipment before and after surgery.*

Action taken

There was a record of one of the equipment counts taking place, but not of others. Although these were taking place, they were not fully documented. Further development is needed to improve record-keeping. We have looked at this again under Quality Statement 1.6. **This recommendation is not met** (see recommendation d).
Recommendation

We recommend that the service should ensure that all staff are aware of, and comply with, standard infection control precautions.

Action taken
During this inspection, we looked at cleaning and infection control arrangements. Our findings are reported under Quality Theme 2. This recommendation is met.

Recommendation

We recommend that the service should ensure that a system is in place to check the quality of domestic cleanliness.

Action taken
During this inspection, we looked at cleaning and infection control arrangements. Our findings are reported under Quality Theme 2. This recommendation is met.

Recommendation

We recommend that the service should develop cleaning schedules to guide staff who are cleaning the theatre areas.

Action taken
During this inspection, we looked at cleaning and infection control arrangements. Our findings are reported under Quality Theme 2. This recommendation is met.
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.1
We ensure that service users and carers participate in assessing and improving the quality of information provided by the service.

Grade awarded for this statement: 4 - Good
Patients could provide feedback on the quality of information provided by the service by:

- using the comments boxes, which were placed throughout the hospital
- making a comment online using social media
- telephoning the customer services helpline, or
- writing a letter and making a complaint.

There was evidence that comments made by patients were responded to. Staff told us that a patient had commented on scan results not being available when they attended for an appointment. This was investigated and a change was made to supply two copies of the scan results; one to the doctor and another to the patient’s healthcare record. This aims to support patient appointments.

Area for improvement
There was little evidence of patients being involved in improving the quality of information provided by the service. The inpatient questionnaire contained no specific questions to gauge patient satisfaction about the different types of information available, for example in relation to written or verbal information, or information contained on the website. Patients could be asked to grade the quality of information available and the results of this feedback could be shown more publically. For instance, using a newsletter or the website to show the actions that have been taken.

- No requirements.
- No recommendations.

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
We were told that information is sent out to patients at the time of booking appointments. This includes:

- information about the specialty service the patient is due to attend
- a map of how to get to the hospital, and
- a letter confirming the appointment date, time, location and consultant.
A leaflet is available for each specialty. The leaflets set out a guide to the costs and charges for private consultations, investigation or treatment. However, these have to be confirmed by the consultant before any procedure or treatment takes place. Private patients are then billed using the hospital billing system or using a separate invoice from the consultant.

Patients attending as an inpatient or for a day case procedure are also sent a booklet called ‘Admissions and discharge information for inpatients and day case patients’. This booklet contained comprehensive information about the hospital and the services it provides, as well as a list of useful contact numbers and frequently asked questions and answers. There was helpful information about:

- what to expect on the day of admission
- what to bring on the day of admission
- discharge information
- caring for surgical wounds, and
- reducing the risk of deep vein thrombosis.

Two additional leaflets are also available to provide information on ‘Having a general anaesthetic’ and ‘having a local anaesthetic or sedation’. These leaflets were informative and outlined what could be expected, as well as some of the possible risks associated.

Staff appeared to be proactive in providing information to patients. This included verbal information. The customer services helpline is available for any telephone queries. Staff in the various departments could also provide verbal explanations and information to help patients to decide if the service could meet their needs.

The hospital website contains comprehensive information about the specialties the hospital provides and the consultants who practise within the hospital. Consultant biographies are in the process of being updated. A project was carried out to make sure that all consultants provided a standard minimum amount of information to help patients decide if they want to use their services.

Staff told us that information could be supplied in large print on request. The interpreter service for patients whose first language is not English was used regularly. We were told that private patients were charged for this service, but NHS patients were not.

During the inspection, we spoke with four patients. All were satisfied with the level of information they had received. The patients in the inpatient ward said they felt fully informed and had received good information before admission.

**Area for improvement**

The ‘Please talk to us’ leaflet outlines how a patient could raise a concern or complaint. The flow chart at the back of the leaflet stated that patients could contact Healthcare Improvement Scotland. However, there were still some leaflets in circulation which had out-of-date details. Some leaflets had a label attached to them with the correct details. However, this was not always the case. This should be reviewed and rectified to make sure patients have the correct information. This was previously identified as a recommendation in the October 2013 inspection report for Spire Murrayfield Hospital (see recommendation a).

More information could be provided for new patients about the car parking facilities available and the layout of the hospital site.
No requirements.

**Recommendation a**

- We recommend that the service should review its ‘Please talk to us’ information leaflet to include the correct contact details for Healthcare Improvement Scotland. This will guide patients to Healthcare Improvement Scotland if they want to make a complaint.

**Quality Theme 1 – Quality of care and support**

**Quality Statement 1.1**

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

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

The inpatient questionnaire was the main method of gaining feedback from patients on the quality of care and support. This contained specific questions on:

- being involved in decisions
- being able to talk about worries
- medications and side effects
- being treated with dignity and respect
- care and attention from nurses
- the quality of food
- discharge arrangements, and
- pain management.

We saw high levels of satisfaction in the results obtained.

During the inspection, we looked at four consent forms. These showed that the risks of the surgery or procedure being carried out had been fully explained to the patient. The consent to carry out the procedure was evidenced by signatures of both the patient and doctor. This showed that patients are involved in making essential decisions.

Other methods of gaining feedback from patients on the quality of care and support were available. These included:

- using comments cards
- social media
- the complaints process, and
- an annual patient survey covering Spire Murrayfield Hospital and Shawfair Park Hospital.

Of the four patients we spoke with during the inspection, all stated that the care and attention received had been ‘excellent’.
**Areas for improvement**

There was no formal policy on how to obtain feedback from patients and how to respond to it. The development of a formal policy could outline this activity clearly and benchmark expectations so that it can be measured for effectiveness (see recommendation b).

Staff told us that the feedback obtained was responded to and we saw examples of comments made by patients in the inpatient questionnaire. However, this could be made more public. For example, the inpatient survey, and action plans which have been produced as a result, could be displayed in a ‘You said, we did’ format and be made available through the service’s website and newsletter.

- No requirements.

**Recommendation b**

- We recommend that the service should develop a formal patient and relative’s participation policy.

---

**Quality Statement 1.4**

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

Grade awarded for this statement: 5 - Very good

The pharmacy department provides pharmacy services to Spire Murrayfield Hospital and Shawfair Park Hospital.

During the inspection, we spoke with the pharmacy manager. They told us that pharmacy staff visit the wards every day to check medicines and prescriptions. Staff ensure that all prescriptions are completed correctly and also check that different prescribed medications can be used safely together. This reduces the risk of different medications reacting with each other and causing adverse symptoms for patients.

During the inspection, we looked at three prescription sheets. We found that all were completed correctly. The prescriptions included the patient’s name, date of birth and any allergies. All prescriptions were legible and had been signed and dated by the prescribing doctor. The prescriptions also identified the dose of the medicine, the frequency it should be taken and the method it should be administered, for example by mouth or injection. We saw that all medication, administered routinely, was signed as being given by a member of nursing staff. All medication which was prescribed, for example pain relief, had been signed correctly. The pharmacy manager also carries out a monthly drug chart audit to ensure compliance.

On occasion, a patient may bring medication into the hospital that is needed during the day. The service has systems in place for medicines reconciliation. Medicines reconciliation is when staff ensure that the medication being prescribed to a patient in the community is continued in the hospital, if appropriate. The medication record has an area to record details of the type of medication and numbers brought in by the patient. A staff nurse was able to explain to us how the medication would be checked to ensure its suitability for use in line with the medication policy and confirmation of the prescription with the patient’s relative.
Pharmacy staff check any medications which patients have brought with them to the hospital. They also make sure that medications, which service users take home on discharge, have been properly prescribed.

We spoke with the pharmacy manager about the management of controlled drugs. These are specific medicines that need to be recorded and signed for by two members of ward staff. Pharmacy staff check that the controlled drug register has been completed by carrying out regular audits. Staff also keep a running balance of controlled drugs within the hospital. In the wards, a daily balance of the controlled drugs is done at the change of each shift.

The hospital has a dedicated area for dispensing chemotherapy medication. This allows pharmacy staff to check all the medication in a quieter environment with fewer interruptions. This helps to reduce the potential risk of medication errors happening. All chemotherapy prescriptions are checked by two members of pharmacy staff before the medication is dispensed. The medication is then checked by two nurses in the ward before being given to a patient.

Staff are required to carry out online training and competency checks before they are allowed to administer medication to patients. This also includes all bank and agency staff. The competency checks include an assessment of the nurse's knowledge of medication and a period of supervised practice.

We were told that any medication errors are discussed at the clinical governance meetings. We reviewed a sample of the minutes of these meeting and confirmed that this does take place. At this meeting, particular trends, medication errors or areas for learning can also be discussed.

Area for improvement

Although staff were adhering to the medication policy for the checking of patients’ own medications for suitability and recording this, the policy makes no reference to using two sources to verify the prescriptions and medications brought in, which is best practice. However, staff told us that this was the practice they were following although there was no place to record this (see recommendation c).

- No requirements.

Recommendation c

- We recommend that the service should develop the medication policy to include two sources to verify prescription of patients’ own medication and provide a place for this to be recorded.

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

The service has a clear organisational structure in place. Each department has health and safety representatives. All representatives attend the health and safety committee meetings every 3 months. Mandatory training is provided for staff through the online ‘Access
Academy'. This includes fire, health and safety, and manual handling. Senior staff monitor training closely to ensure compliance. A health and safety noticeboard provides up-to-date information to staff, including representatives and leads, for specific areas and the most recent committee meeting.

We saw that Control of Substances Hazardous to Health (COSHH) information and risk assessments were in place and were managed by each department. A system was also in place to ensure staff have read and signed to confirm that they have read this information.

The hospital uses the Datix system. This is an online accident, incident, risk and complaints reporting software package which collates all relevant data for recording, archiving and reporting purposes. Risks are assessed using a scoring and rating system.

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. Different pathway records were held for patients, depending on the procedure and length of stay. Essential details, such as next of kin and consent to treatment, were also recorded. Consent forms were 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. All were completed, signed and dated. These included:

- falls
- moving and handling
- pressure ulcers
- malnutrition
- use of bedrails
- venous thromboembolism (blood clot related) incidents, and
- a theatre safety checklist.

The World Health Organization (WHO) has issued guidelines entitled ‘Safe Surgery Saves Lives’. This details best practice for performing surgery in a safe way. During the inspection, we followed a patient’s journey from the ward to theatre and the recovery room. We saw that 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 WHO guidelines.

Another recommendation is for staff in the theatre to have a ‘time out’ 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. 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 on the patient. 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.

A tourniquet was used during the observed operation. A tourniquet is a device used to restrict blood flow to a particular part of the body during an operation. Current national guidance states that the number of times the tourniquet is applied and removed should be announced to the surgical team and noted in the patient care record. We saw that staff followed this guidance.
We saw that patients were accompanied to and from the theatre department by a nurse. We saw that close monitoring of patients took place during the induction of anaesthetic, during the operation and in the recovery room. Observations were recorded approximately every 5 minutes. This was good practice. We saw that there was a daily checklist for equipment used in theatres, and anaesthetic machines were checked daily and recorded.

We saw that the service completes audits on various aspects of patient safety. Staff who carry out the audits select patient care records at random to review. The audit ensures:

- patient temperature checks are recorded
- venous thromboembolism (blood clot related) prophylaxis compliance
- tourniquet times are recorded, and
- the WHO surgical safety checklist is signed.

**Area for improvement**

Stand-alone heaters are used in some of the patient rooms to ensure that patients are warm enough. As patients can be confused after surgery, it is essential that risk assessments are carried out to ensure the heaters are suitable to use (see requirement 1).

Although swab, needle and instrument counts were seen to be carried out, only the final count was documented. Best practice would record all counts which take place during an operation (see recommendation d).

Through discussions with staff, it was noted that some incidents were not being recorded on the Datix system as staff felt they were not serious or their action had prevented anything from happening. These incidents should still be recorded even if they are considered to be 'near misses'. The service should ensure all incidents are recorded on the Datix system (see recommendation e).

**Requirement 1 – Timescale: by 30 November 2014**

- The provider must ensure that risk assessments are used to determine the safety for individual patients to use stand-alone heaters.

**Recommendation d**

- We recommend that the service should ensure that all swab, needle and instrument counts are recorded in the theatre register.

**Recommendation e**

- We recommend that the service should ensure that all incidents and near misses are recorded on Datix to ensure learning points are identified.
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: 5 - Very good
A variety of options were available to allow patients to provide feedback on the quality of the hospital environment. The main method used was the inpatient questionnaire. This asked for feedback on:

- privacy to discuss treatment
- the cleanliness of the room and hospital, and
- the quality of the room and surroundings.

Area for improvement
Further development could take place to gain views about the accessibility of facilities and the suitability of the environment for children. Some comments were made about environmental factors, such as the television not working or the bed being too short. The response to such comments could be recorded to ensure that actions have been taken.

The comments made in Quality Statement 1.1 are also relevant to this quality statement.

- No requirements.
- No recommendations.

Quality Statement 2.2
We are confident that the design, layout and facilities of our service support the safe and effective delivery of care and treatment.

Grade awarded for this statement: 4 - Good
Staff and visitors use a sign-in and sign-out system to enter the hospital. Some areas of the hospital can only be accessed using a keypad and touch fob. This helped the security of the building.

The service had operational policies in place which provided guidelines on the maintenance of clinical and non-clinical equipment. The hospital engineer controlled corporate contracts for equipment servicing. An asset register listed all the equipment. Maintenance issues for the building and equipment were reported through an online system, which generated work orders. Staff spoken with were familiar with procedures for reporting repairs.

We saw evidence that inspections have taken place to check water supplies and ventilation systems, including laminar flow systems for theatre. Action plans have been put in place which outline further work required. We saw evidence that fire risk assessments have taken place and action plans were produced.

During the inspection, we spoke with the sterile supplies department manager. This department sterilises the equipment that will be used in theatre. They had good systems and
processes in place to check, calibrate and document the equipment required, with annual maintenance being carried out. We saw evidence of the service using an external organisation to assess and certify the unit’s compliance with current national standards.

In the theatre department, we saw evidence of equipment checks being carried out. We saw that a daily checklist for equipment was used in theatres, and anaesthetic machines were checked daily and recorded in folders provided. We saw that the anaesthetic trolleys were laid out in a way that made identification of equipment easy, reducing risk in airway emergencies.

We visited the radiology department. We saw evidence of external accreditation and regular maintenance systems in place.

We saw evidence that medication fridges and room temperatures were being checked and recorded regularly. This helps to ensure the safe storage of medication.

During the inspection, some areas of the hospital were undergoing major refurbishment, including the consulting rooms in Beechwood House and the outpatients department. There had also been improvements made to some of the en-suite facilities in the patient rooms, where new showers of a very high standard had been fitted.

**Areas for improvement**

Although daily checks were carried out and recorded for anaesthetic machines, additional maintenance records for weekly and monthly checks were not available. Anaesthetic machines should be checked regularly to make sure:

- they are safe
- they are in good working order, and
- that the filters and other parts are replaced as required.

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 replaced. This is to allow tracking and traceability of the equipment in the event of a fault occurring (see recommendation f).

During the inspection, we saw some equipment stored in the ground floor ward corridor. Although this did not block the corridor alternative storage areas would be beneficial.

We saw that there had been some damage to the walls of the first floor ward. This was caused by beds being pushed along the corridors and hitting the walls. Consideration could be given to fixing protective cladding to the walls.

The doors had been removed from a cupboard in the ground floor sluice room, which left open shelving. Ensuring that any items stored in the sluice room are protected from potential contamination would be good infection control practice (see recommendation g).

Some areas of the hospital were not wheelchair accessible. The management team was aware of these limitations and could provide alternative consulting or treatment rooms, if needed.

There were some toys available for children in the oncology unit. However, other areas had not been made child-friendly. Consideration could be given to having an area which is more appropriate for consultation or the treatment of children.
■ No requirements.

Recommendation f
■ We recommend that the service should keep detailed records of the additional weekly and monthly checks and maintenance of the anaesthetic machines along with the serial numbers of circuits as they are replaced.

Recommendation g
■ We recommend that the service should enclose the shelving in the ground floor sluice room to improve the control of infection.

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: 5 - Very good
During the inspection, we saw a range of infection protection and control policies in place. These provide staff with guidance on various aspects of infection prevention and control.

We saw that all staff were compliant with the national dress code policy. This policy outlines how staff should dress, when in the hospital, to reduce the risk of spreading infections. This includes being bare below the elbow and not wearing jewellery. This allows staff to wash their hands more effectively.

In the areas of the hospital we inspected, the standard of cleaning was very good. We spoke with the hotel services manager, who was able to show us the systems and processes in place for cleaning the hospital. This included:

• cleaning schedules
• daily walkabout and checking systems (with housekeeping staff)
• monthly audits, and
• action plans.

Systems were also in place for ongoing cleaning, such as curtain changes, and deep cleaning patient rooms. COSHH risk assessments were also present, relevant and up to date.

During the inspection, clinical staff spoken with were able to describe and demonstrate the systems and process in place for cleaning clinical areas and equipment.

A lead nurse for infection control is responsible for infection control activity at Spire Murrayfield Hospital and Shawfair Park Hospital. The lead nurse has 3 days each week allocated to infection control duties across both hospitals. This includes supporting staff, carrying out audit activity and surgical site infection surveillance. We were told that more time is available for this role, if required. There are also link nurses in each of the departments. An
infection control link team meeting is held every 2 months and an infection control committee meeting is attended by department heads and feeds into the clinical governance group.

We saw that the service completes audits on various aspects of infection prevention and control. These audits include:

- hand hygiene practices
- linen management
- waste management
- mattress checks, and
- the use of sharps.

All patients spoken with stated that the standard of cleanliness was 'very good'. They also stated that the ward environment, and hospital, was pleasant, welcoming and clean.

Areas for improvement

Although there were some written cleaning schedules to guide clinical staff and record that cleaning had taken place, these were not very specific and need to be developed further (see recommendation h).

The service has a number of infection control initiatives and audits in place. However, the care bundles for the insertion and maintenance of peripheral venous catheters (PVCs) could be further developed. PVC bundles are used to reduce the risk of device-related bloodstream infections. This includes a record to document the safe management of the inserted PVC. The bundle includes documenting daily checks to make sure that the PVC is free from any signs of inflammation and is still required.

- No requirements.

Recommendation h

- We recommend the service should develop daily, weekly and monthly cleaning schedules to guide clinical staff who are cleaning the clinical areas and equipment and develop a system of checking this.

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: 5 - Very good
A variety of methods were in place to allow patients to provide feedback on the quality of staffing. The main method used was the inpatient questionnaire. This asked patients to grade the quality of performance of specific staff roles, for example consultants, nurses and theatre staff.

Area for improvement
The comments made in Quality Statement 1.1 are also relevant to this quality statement.
We saw some positive and negative comments made about staff performance. It would be beneficial to see the actions taken in response to these comments.

- No requirements.
- No recommendations.

**Quality Statement 3.3**

*We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.*

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

During the inspection, we looked at four staff files: three were from the theatre department and one was from the ward. We saw that all of the relevant recruitment checks had been carried out. Improvements had taken place recently to standardise the file layout between departments and this made the files easy to follow and audit.

Consultants also undergo a process of checking before practising privileges are granted. This involves:

- accepting the consultant handbook
- nominating a depute who can stand in, if required, and
- providing a copy of indemnity insurance.

The service reviews the consultants’ practising privileges every 2 years. All doctors have to carry out a revalidation process every year, in order to maintain their registration with the General Medical Council. For consultants whose only practice was within the private hospital, revalidation arrangements were in place which involved the director of clinical service for Spire Healthcare Ltd.

Regular checks are made of staff who are registered on professional registers, for example the General Medical Council or Nursing and Midwifery Council.

The service had an induction process for all staff groups. The staff training files we looked at contained copies of induction information. The majority of these were signed off to demonstrate that the subject areas had been discussed or demonstrated.

We saw comprehensive systems in place to support staff with training and development. This was called the ‘Enabling Excellence’ programme. This incorporates a set of core values and behaviours which all staff are expected to adhere to.

Staff have their own log-in details for an online training programme called the ‘Access Academy’. A training card sets out the modules which are expected to be carried out every year. This system was monitored to ensure staff completion throughout the year. Each staff member had their own training and performance goals. This was monitored by the heads of departments. This system ensured regular meetings were held between staff and line managers to ensure training and support needs were being met.

Staff told us that they felt well supported and they were aware of key policies, such as the whistle-blowing policy and the protection of vulnerable adults.
Resuscitation training was a mandatory subject for clinical staff. We were told that a rota system was in place to identify which staff would be part of the emergency call-out team for each day.

We asked patients what they thought of the staff in the hospital. All patients spoken with stated that staff were extremely helpful, very courteous and attentive. One patient said the care equated to that of a ‘first class hotel’.

**Areas for improvement**

Not all areas of the induction workbook were completed for some staff. We found that much of the workbook was carried out by self-assessment and had not been signed off by a manager or by peer support. Consideration could be given to reviewing and strengthening this system.

Some of the competency workbooks were due for review. This would help staff to be more up to date in their practice. We will follow this up at future inspections.

One member of staff told us that some practices carried out may not be clinically effective. For example, some consultants use a one-off dose of intravenous antibiotic when a urethral catheter (drainage tube placed into the bladder) is removed. There was a suggestion from staff that the evidence for this practice is inconsistent and therefore this would benefit from further discussion to gain a best practice viewpoint as overuse of antibiotics is a concern.

Another example was the inconsistent approach to the prescribing of anticoagulant medications. Anticoagulants prevent our blood from clotting. Some consultants choose not to follow the guidance of SIGN meaning that not all consultants use the same prescribing practices. The hospital management team are aware of this and work closely with the doctors to support their clinical preferences. However, this means that there is inconsistent practice within the hospital and this inconsistency is not immediately clear to patients.

When we spoke to a manager about this, there was agreement that some consultants ask for practices to be carried out as this is their preferred way of working. Moves should be made to ensure that all practices are evidenced based. Staff should also be encouraged to challenge any practice and be supported in doing so (see recommendation i).

The rules which allow consultant specialists to work at the hospital were not publically available. Consideration could be given to making this clearer on the website and stating what checks are carried out and how this is monitored.

- No requirements.

**Recommendation i**

- We recommend that the service should ensure that staff practices are clinically effective and any practice which is not should be challenged and such challenges supported.
Quality Theme 4 – Quality of management and leadership

Quality Statement 4.1
We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service.

Grade awarded for this statement: 5 - Very good
A variety of methods were in place to allow patients to provide feedback about the quality of management and leadership within the hospital. The inpatient questionnaire asked about the overall experience of the services provided by the hospital. There was also an option to grade the questions.

A patient forum was in place which could be used as a consultancy group. This group communicated using social media. Consultation has taken place recently about the hospital’s 30-year anniversary.

All patients spoken with were aware of the complaints procedure and stated that they felt comfortable to raise issues if they needed to.

Area for improvement
The comments made in Quality Statement 1.1 are also relevant to this quality statement.

Involving the patient forum in the self-assessment process, and future strategy or development plans, could be considered.

■ No requirements.
■ No recommendations.

Quality Statement 4.4
We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Grade awarded for this statement: 5 - Very good
We found that the service had quality assurance systems in place. The quality assurance structure is made up of the following groups:

- the health and safety committee
- clinical effectiveness committee
- infection control committee
- blood transfusion committee
- accountable officers local information network (for controlled drugs), and
- the management review team.

These groups meet regularly. Any trends and important issues are passed to the clinical governance committee. Overall, accountability rests with the medical advisory group. This group is made up of representatives, including doctors and consultants, who work at Spire Murrayfield Hospital. This structure is relatively new, having been revised in May 2014.
We looked at minutes of recent clinical governance and clinical effectiveness meetings. We could see that significant adverse events and root-cause analysis of these events were discussed to identify learning points and actions to be taken.

Quality and risks are monitored using a clinical ‘scorecard’ which has been developed by the corporate clinical governance group. This scorecard was used to monitor a number of key indicators, such as:

- pain management
- risk and number of venous thromboembolism (blood clot related) incidents
- infection control and surgical site infection surveillance
- pressure ulcers, and
- complaints.

The service regularly audited patient care records to check completion of important areas. A ‘mini-audit’ had been carried out recently to look at the incidents of falls. The pharmacist also regularly logged and reviewed medication incidents.

The service has a complaints log which details all of the complaints received from patients. We viewed this log and could see that complaints were monitored to ensure responses were made within set timescales.

There was a consultant survey which gave feedback on aspects of the service.

A staff engagement survey was in progress. The service was encouraging staff to complete this survey. An annual patient survey was also carried out independently and analysed by an external company to help ensure impartial results were gathered.

All of these elements give a comprehensive level of checking and quality assurance.

**Area for improvement**

The clinical governance arrangements were relatively new and so we could not fully assess the effectiveness of the change to the structure. We will review this at future inspections.

We reminded the hospital management team about the notification guidance to Healthcare Improvement Scotland. During the inspection, we noted a medication administration error involving a controlled drug which had not been notified to Healthcare Improvement Scotland.

There was no specific method in place for obtaining the views of relatives or visitors. This could be considered for the future. We also did not see any specific feedback from the NHS as a stakeholder of the service. There has been a rise in work carried out by private hospitals on behalf of the NHS, therefore this could be developed further.

- 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 Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

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

### Quality Statement 0.2

**Requirements**

None

**Recommendation**

We recommend that the service should:

a  review its ‘Please talk to us’ information leaflet to include the correct contact details for Healthcare Improvement Scotland. This will guide patients to Healthcare Improvement Scotland if they want to make a complaint (see page 11).

National Care Standards – Independent Hospitals 9.4 – Expressing your views

### Quality Statement 1.1

**Requirements**

None

**Recommendation**

We recommend that the service should:

b  develop a formal patient and relative’s participation policy (see page 12).

National Care Standards – Independent Hospitals 9 – Expressing your views

### Quality Statement 1.4

**Requirements**

None
Recommendation
We recommend that the service should:

c develop the medication policy to include two sources to verify prescription of patients’ own medication and provide a place for this to be recorded (see page 13).

National Care Standards – Independent Hospitals 20.0 – Medicines management

Quality Statement 1.6
Requirements
The provider must:

1 ensure that risk assessments are used to determine the safety for individual patients to use stand-alone heaters (see page 15).

Timescale – by 30 November 2014

SSI 2011 No. 182 - Regulation 3a) make proper provision for the health, welfare and safety of service users.
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Recommendations
We recommend that the service should:

d ensure that all swab, needle and instrument counts are recorded in the theatre register (see page 15).

National Care Standards – Independent Hospitals12.4 – Clinical effectiveness.

This recommendation takes into account - Second Global Patient Safety Challenge: Safe Surgery Saves Lives (WHO 2009).

e ensure that all incidents and near misses are recorded on Datix to ensure learning points are identified (see page 15).

National Care Standards – Independent Hospitals12.1 – Clinical effectiveness.

Quality Statement 2.2
Requirements
None

Recommendations
We recommend that the service should:

f keep detailed records of the additional weekly and monthly checks and maintenance of the anaesthetic machines along with the serial numbers of circuits as they are replaced (see page 18).
Your environment

g  enclose the shelving in the ground floor sluice room to improve the control of infection (see page 18).

National Care Standards – Independent Hospitals 13.1 – Prevention of Infection

Quality Statement 2.4

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>h  develop daily, weekly and monthly cleaning schedules to guide clinical staff who are cleaning the clinical areas and equipment and develop a system of checking this (see page 19).</td>
</tr>
</tbody>
</table>

National Care Standards – Independent Hospitals 13.1 – Prevention of Infection

Quality Statement 3.3

<table>
<thead>
<tr>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We recommend that the service should:</td>
</tr>
<tr>
<td>i  ensure that staff practices are clinically effective and any practice which is not should be challenged and such challenges supported (see page 21).</td>
</tr>
</tbody>
</table>

National Care Standards – Independent Hospitals 12.2 – 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>23/10/2013</td>
<td>5 - Very good</td>
<td>4 - Good</td>
<td>4 - Good</td>
<td>Not assessed</td>
<td>5 - Very 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:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>excellent</td>
</tr>
<tr>
<td>5</td>
<td>very good</td>
</tr>
<tr>
<td>4</td>
<td>good</td>
</tr>
<tr>
<td>3</td>
<td>adequate</td>
</tr>
<tr>
<td>2</td>
<td>weak</td>
</tr>
<tr>
<td>1</td>
<td>unsatisfactory</td>
</tr>
</tbody>
</table>

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](http://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>Definition</th>
</tr>
</thead>
<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.