Unannounced Inspection Report: Independent Healthcare

PiC Ayr Clinic | Partnership in Care Scotland Ltd | Ayr

20–21 January 2015
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1 A summary of our inspection

About the service we inspected

PiC Ayr Clinic is a 36-bed independent psychiatric hospital providing low secure facilities for men and women with a mental illness, mild learning difficulty, personality disorder or acquired brain injury.

The hospital has 34 ensuite single bedrooms within a two-storey purpose built facility. There are three wards: Arran, Belleisle and Low Green. The hospital has recently added a self-contained flat for two patients, known as the transitional assessment service. This is for patients preparing for discharge. All wards have access to an external garden and a smoking area.

The service aims and objectives state: ‘At the Ayr Clinic, treatment is based on our belief that recovery is possible. We work with patients providing care, treatment and support to allow them to reach their potential, regain life skills and have the confidence and self-esteem to build their own futures.’ Great importance is placed on treatment outcomes which include risk reduction, relapse prevention, independent living skills, vocational engagement and social inclusion.

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 PiC Ayr Clinic on Tuesday 20 and Wednesday 21 January 2015.

The inspection team was made up of two inspectors: Karen Malloch and Winifred McLure, and a public partner, Kenneth 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: 5 - Very good
Quality Theme 1 – Quality of care and support: 5 - Very good
Quality Theme 2 – Quality of environment: 5 - Very 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 PiC Ayr Clinic 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 annual return
- any notifications of significant events
- the previous inspection report of 20 March 2014, and
- complaints activity.

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

- accident and incident reports
- audits and surveys
- information leaflets
- minutes of meetings
- policies and procedures
- patient care records for people who use the service
- quality reports
- satisfaction questionnaires
- staff training records
- patient programmes, and
- complaints.

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

- nine people who use the service
- the medical director
- the registered manager
- charge nurses
- chefs
- the housekeeping manager and staff
- the lead nurse
- the occupational therapist
- reception and administration staff
- the hospital services manager
- the maintenance manager, and
- ward staff.

We inspected the following areas:

- a sample of patient bedrooms
- external gardens and smoking areas
- the kitchen
- the maintenance office area
- storage areas
• the inpatient wards
• the reception area, and
• the transitional assessment service.

What the service did well
We noted areas where the service was performing well.

• Patients were involved in most aspects of their care and in developing the service.
• We found a positive staff culture.
• Effective quality assurance systems were in place.

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

• The service should ensure audits are actioned and outcomes are recorded.
• The service should ensure all staff receive regular performance appraisals.
• The website should be updated to ensure current information is readily available.

This inspection resulted in one requirement and six recommendations (see Appendix 1 for a full list). The requirement is linked to compliance with the Act and regulations or orders made under the Act, or a condition of registration.

Partnership in Care Scotland 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 PiC Ayr Clinic for their assistance during the inspection.
2  Progress since our last inspection

What the service had done to meet the recommendation we made at our last inspection on 20 March 2014

Recommendation

*The provider should ensure where appropriate that patients are given access to video calling facilities to allow them to maintain the level of contact they want with their friends and families.*

Action taken

We spoke with patients and staff who told us video calling facilities were available for patients who were able and wanted to use this. This was used by a small number of patients. Staff told us that some families did not have facilities at their home to make video calls. We found that some patients did not want to use the facilities. **The recommendation has been 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: 5 - Very good
The information provided in Quality Statement 1.1 is also relevant here.

■ 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
Patients were given a patient information booklet called 'Welcome to the Ayr Clinic' on admission or before they were admitted. This booklet provided information about the hospital services, including:

- the aims of the service
- the environment and facilities available
- patients' involvement in care and treatment
- patients' legal rights
- how to make a complaint
- staff, and
- therapies and activities.

This booklet was in the process of being updated and we saw a draft of the proposed new booklet. Information about the service was also available on the website.

Pre-admission visits were used to help assess whether or not the patient was suitable for admission to PiC Ayr Clinic and also answer questions the patient may have about the service.

An information booklet was available for family, friends and carers called 'Working in partnership' which gave information on:

- the referral and admission process
- useful contacts and links, and
- visiting procedures.
Information was also available for professionals, detailing services provided by the hospital. This was useful for organisations that may wish to refer patients to the service.

A ward noticeboard contained information about:

- advocacy services
- a poster about the complaints process
- information about health promotion, and
- a ward programme timetable.

Staff told us that events and bulletins would be advertised on this noticeboard. We found information leaflets were also available at reception.

Each ward had a weekly patients forum meeting which helped to give patients information and updates about services and maintenance issues that may affect them.

We saw a draft version of a new ward booklet which would give patients more in-depth information about their specific ward. We looked at the draft booklet and found that it was very user friendly and reflected information that was important to the patients.

**Areas for improvement**

We found Healthcare Improvement Scotland’s contact details in the information booklet was incorrect and needed to be updated.

We also found information on the website was limited and out of date, and did not include information on the transitional assessment unit. This should be updated (see recommendation a).

- No requirements.

**Recommendation a**

- We recommend that the service should review and update its website to reflect the increase in beds and develop the website to give more information to potential patients and their families.

**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 service had a patient involvement strategy which showed how it involved patients in:

- their care, treatment and support, and
- developing the service.

We saw that the service was working through an action plan for this. The strategy was due for review next year.
Patients were involved in updating the new information booklet for the service, which will replace the ‘Welcome to the Ayr Clinic’ leaflet. A working group was in place and ward representatives were in the process of gathering patients’ comments on the new layout. We also looked at the new ward information booklet that patients had produced and was waiting to be published. We found this contained relevant and helpful information for patients and their families.

We attended one of the weekly patients forum meetings. This meeting allowed for open discussion of issues. Patients were encouraged to take minutes, contribute to the agenda and discuss any issues. Recently, patients were also encouraged to chair the meeting, to give them greater ownership of the group.

Ward-based clinical governance meetings were held in each ward every 2 weeks. In minutes of these meetings, we saw patient representatives were invited to attend to give their view on issues affecting them. These meetings fed into the service’s monthly clinical governance meetings, which in turn fed into the provider’s monthly corporate clinical governance meetings.

We saw that patients had one-to-one sessions with their named nurse, responsible medical officer and psychologist to raise any issues about their care and support. Patients were encouraged to attend and take an active part in these review meetings.

Patients were invited to attend their care programme approach meetings with their named person. A named person is someone chosen by the service user to represent and help protect their interests while they are subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. The care programme approach is the way care is co-ordinated to ensure that people with severe mental illness receive appropriate care and services. The service had carried out two audits on the care programme approach process, asking for views from patients. These showed that patients’ view of the process and their involvement had improved over the last 2 years.

Patients had an opportunity to discuss and request changes to their timetable at a weekly meeting with staff.

The service used questionnaires and surveys to encourage feedback from patients on their experience of using the hospital. A formal patient survey has been completed every year and an updated survey will be introduced this year. A separate survey of family and carers was carried out.

We found patients were actively involved in reporting maintenance issues through the patients forum. Patients were also involved in the refurbishment of the hospital through specific working groups. We saw examples of patient views taken into account when making decisions about decoration, use of rooms and soft furnishings.

To encourage patients to become more aware of the risk assessment process, staff had recently introduced risk assessment education sessions. We were told that uptake had been poor, but staff would continue to provide the sessions and invite all patients.

During the inspection, we found patients often took prospective employees on a tour around the ward area or had an informal chat with them. The patients would then provide feedback to the interviewing panel.

A complaints procedure was in place, with information available for patients about how to make a complaint. Patients were supported to use this system to log complaints, compliments and suggestions. Advocacy services visited once a week and more frequently,
as required. During the inspection, we saw information displayed about the advocacy service.

Areas for improvement
The patient and family surveys could be developed further to ask about the information provided to them. The service could encourage and support patients and families to fill in the surveys to get more feedback.

- No requirements.
- No recommendations.

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: 5 - Very good
The service had policies and procedures in place to manage risk. These included guidance to staff on the prevention of abuse, access to electronic devices, whistle-blowing, patient observations, and the management of violence and aggression. Staff we spoke with had a good understanding of policies and procedures.

The staff training matrix showed most staff had completed the mandatory requirements. Staff spoken with had an understanding of their duty to maintain patient and staff safety. All nine of the patients we spoke with told us they felt safe. We saw records that showed any issues or concerns were reported correctly.

Looking at patient care records, we found risk assessments and details of physical interventions were in place where required. The service was moving towards multidisciplinary care planning. We viewed two newly implemented plans around risk and found these were comprehensive. We saw that care plans were discussed with the patients. We also found levels of observations were recorded clearly.

Restrictions to patients were based on individual risk assessment. Staff told us they try to make sure that any restrictions needed for one patient’s safety have minimal impact on other patients.

Procedures were in place for using mobile phones. However, this was being reviewed in response to feedback from patients. We were told the service would consult with the Mental Welfare Commission for Scotland.

To maintain security, certain items were restricted in the service. For example, use of cutlery and razors by patients was closely monitored by staff. Room searches were carried out when staff had concerns that patients were concealing items of risk. During the inspection, one patient told us they were under constant observations and had limited ability to move freely or make decisions.

We noted the service had systems in place to manage leave and detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. We found records were in place to record that patients had been reminded of their rights in relation to the Act.
A dashboard system was in place which provided information on patients and included the level of observations and any safety alerts. An electronic system to report accidents and incidents was also used. This system could provide regular reports on incidents and trends. The system also had current information for managers on incidents reported and outstanding forms needing review. We saw these incidents, reports and trends were discussed at key meetings to identify any actions required in terms of staffing, education or policy.

We noted staff carried mobile alarms which would identify their location in the building if assistance was required. Staff also used walkie-talkies for quicker communication. Alarms and keys were signed in and out daily. All bedrooms had call bells that notified staff when their help was required. Two patients told us they had tried the alarms and staff had responded.

We saw staff had received training in management of violence and aggression. There were two trainers on site. A closed circuit television system was in operation that monitored areas throughout the building. This was used when reviewing incidents.

In partnership with the local hospital, the charge nurse on Low Green ward developed an initiative called ‘fast-track A&E assessment’. The aim of the initiative is to minimise the risk for patients who need to attend the emergency department because they have intentionally hurt themselves. This initiative now ensures patients are fast tracked for treatment, avoiding lengthy, stressful waiting times at the emergency department. The initiative received a Nursing Times emergency and critical care award.

We saw examples of staff security portfolios completed on induction. These were very comprehensive and covered physical security, relational security, keys and searches. A designated member of staff co-ordinated security on each shift and checklists were completed to show checks were being carried out as required.

We saw patients requiring personal emergency evacuation plans had these in place. Visitors to the unit were required to sign in. The doors at reception were secure with intercom and airlock systems. Visitors were offered use of a locker to store mobile phones and other prohibited items during their visit.

The unit risk register was a comprehensive document that was regularly reviewed through the clinical governance structures.

**Areas for improvement**

We noted that fire safety training was not provided to patients. This should be considered to ensure all patients are aware of the procedures in case of a fire (see recommendation b).

The smoking areas should be reviewed to ensure appropriate fire safety equipment is readily available in the event of a fire (see recommendation c).

- No requirements.

**Recommendation b**

- We recommend that the service should provide patients with information about what to do in case of a fire.
Recommendation c

- We recommend that the service should review the smoking areas to ensure that appropriate fire safety equipment is located adjacent to the area.

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
The information provided in Quality Statement 1.1 is also relevant here.

- 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: 5 - Very good
During the inspection, all patients within the service were detained under the Mental Health Act Scotland (1983) as such a balance has to be made between patient safety and providing the least restrictive environment for them.

The unit was purpose built and all bedrooms were single with ensuite shower rooms. The bedrooms were built with a safety specification which minimises risks to patients who may deliberately self-harm or were suicidal. We noted the bedrooms were a good size and patients had been able to personalise their rooms. Staff could observe the patients through the room’s door panel but these panels can be adjusted to ensure privacy. We were told that the door panels were not used regularly.

We saw that the service was clean and well maintained. We spoke with the housekeeping staff who showed us how the cleaning schedules directed their daily work. We were told of the challenges in maintaining a clean environment with patients who were often unwell or reluctant to leave their rooms. Housekeeping staff told us communication with ward staff was essential in ensuring safety and minimal disruption. We were told staff groups communicate effectively with each other.

A maintenance team responded to requests and managed on-site contractors. We looked at the maintenance records that showed requests were actioned and that each ward got feedback when jobs had been completed. We also found evidence that this information was passed on to patients to make sure they were kept up to date.

A health and safety committee met once a month. In minutes of the meeting, we saw discussion included policy review, audit and staff training.

We found staff had made considerable effort to support patients’ involvement in decisions about the environment. Many areas were brightly decorated and patient art and photograph projects were displayed. An artist had been commissioned to work with patients to develop a
mural for Belleisle ward. We saw plans of a concept, chosen by patients, to depict a recovery tree with the ward name.

Communal facilities included quiet rooms, a gym and a games room. All wards had a kitchen area that was open for patients to have drinks and snacks. We saw that given the restrictions on space, the option of using rooms for multi-function purposes was well used.

There were plans to develop a sensory room on Arran ward.

**Areas for improvement**

Patients brought in a high volume of electrical equipment and gadgets. We looked at electrical items on the wards and noted that some had not had portable appliance testing carried out. The maintenance manager was aware of these outstanding tests (see recommendation d).

We found the unit had poor provision of storage and office space was tight. The manager told us there was a proposal for additional external storage and a review of office space to increase capacity was under way.

The reception area was small and did not have a welcoming atmosphere. The service could consider how to improve this space.

We reviewed the external area and saw that ashtrays were not emptied in the Arran ward smoking area. We found cigarette ends were overflowing from a bucket. We also found an accumulation of cigarette ends outside one external door. A regular schedule of emptying and cleaning bins should be introduced.

The clinical hand wash basins in the treatment areas were not compliant with Health Technical Memorandum (HTM) 64 - Sanitary Assemblies, Department of Health, February 2006 (Basin assemblies for use in connection with clinical procedures) (2006). Replacement sinks should be factored in to future refurbishment programmes (see recommendation e).

- No requirements.

**Recommendation d**

- We recommend that the service should carry out portable appliance testing on all portable electrical appliances.

**Recommendation e**

- We recommend that the service should identify all clinical hand wash basins and assess them based on current guidance. The clinical hand wash basins that are not compliant with current standards should be upgraded in line with a risk-based plan that takes into account both the use of the basin and its design.
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
The information provided in Quality Statement 1.1 is also relevant here.

- No requirements.
- No recommendations.

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

Grade awarded for this statement: 5 - Very good
During the inspection, we saw numerous examples where staff were supporting people in a positive and respectful manner. We saw evidence of an induction programme which contained a core value of respect for all. Equality, diversity and human rights training was carried out at induction and were part of the mandatory training for all staff.

Weekly patients forum meetings were held where patients could voice any complaints or concerns, express their views and ask questions. We attended a meeting and saw that patients were listened to and their opinions respected.

A very good supervision framework was in place, with all clinical staff having access to regular formal supervision. Informal, daily supervision was recorded in the staff supervision passport. Staff we spoke with were aware of their responsibility to report poor practice and were aware of the whistle-blowing procedure. Staff told us they would be comfortable using the procedure if required. All staff we spoke with were motivated and enjoyed their work.

We saw that the service was beginning to use a new patient satisfaction survey which asked questions about staff interaction with patients.

All staff and patients we spoke with felt that they were treated with dignity and respect.

Management told us that relationships between staff and patients could be challenging. For example, if a patient was unwell and physical interventions were required, this may have an effect on patient’s trust. Relationships with named nurses were reviewed regularly and changes were made if the patient viewed the relationship negatively.

Area for improvement
Some staff were overdue their mandatory equality, diversity and human rights training. We noted, however, that there was a training session being carried out the day after our inspection.

- No requirements.
- No recommendations.
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
The information provided in Quality Statement 1.1 is also relevant here.

- 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
The service submitted a comprehensive self-assessment to Healthcare Improvement Scotland. This self-assessment is completed by the service each year and provides a measure of how the service has assessed themselves against the quality themes and national care standards. We found very good quality information that we were able to verify during our inspection.

The organisation had a quality assurance framework in place that encouraged patient and staff involvement. The service monitored quality in a number of ways, including:

- accident and incidents
- audits
- care reviews
- clinical indicators
- complaints
- patients forum meetings
- staff meetings, and
- surveys.

A clinical governance system was in place to make sure all data gathered was reviewed, any trends were identified and used to inform management and staff about how the service was performing. We looked at minutes of the clinical governance meetings. These minutes showed discussion about important aspects of service delivery, including:

- policies and procedures
- risk management
- staffing information, and
- collected data.
The provider held a monthly corporate clinical governance meeting, where representatives from the service attended. The meeting discusses reports on various aspects of the service and this information is used to review how the service is performing. For example, reports showed that staff training was up to date, patient incidents had been reduced and patient leave was high. These are positive indicators of service delivery. Monthly reports also showed incidences of physical interventions, community meetings, primary nurse sessions and patient activity.

Various meetings and committees included patient forums, weekly ward management meetings, daily multidisciplinary meetings and a range of specialist meetings, including a security committee. The senior management team met daily, Monday to Friday. These meetings gave staff the opportunity to discuss any incidents from the last 24 or 72 hours as well as referrals, assessments, discharges, staffing and complaints.

We looked at complaints and the service’s response. We saw the service acknowledged complaints within the timescales outlined in the complaints procedure. We saw an example where a complaint had resulted in improvements in communication with mental health officers through monthly progress reporting.

To make the care planning process more meaningful, the service had implemented the Scottish Recovery Indicator 2 (SR12) framework. This allowed patients to provide feedback to the service about how their needs were being met. The feedback included:

- nutrition
- housing
- personal safety
- spirituality, and
- housing.

We found the SR12 provided a structured framework for evaluating service delivery.

The provider carried out a compliance audit twice a year by the provider’s compliance manager. We looked at the last audit of August 2014 and found it to be a positive report. Any issues identified were included on an action plan and addressed.

Patients forum meetings were held weekly and we saw that medical staff also attended.

**Areas for improvement**

We looked at audits carried out by the service and found action plans resulting from them were not consistently well completed. This meant that although the actions may have been carried out, they were not always recorded. The service should ensure audit action plans are current and reflect progress and outcomes (see recommendation f).

While audits around medication management were in place, the service should consider auditing the use of medication administered to patients only when a situation requires it. This is called ‘as required’ medication. In particular, the use of psychotrophic drugs, which affect behaviour and mood, should be audited. This would help to determine whether care plan strategies are effective.

We saw that while systems and processes were in place for staff supervision and appraisal, all staff had not received an appraisal (see requirement 1).
Requirement 1 – Timescale: 17 July 2015

■ The provider must ensure that all staff receive regular performance review and appraisal.

Recommendation f

■ We recommend that the service should ensure that when audits are carried out, action plans are developed in response to issues identified and that these are kept up to date to show progress.
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>
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<tbody>
<tr>
<td><strong>Requirements</strong></td>
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<td>None</td>
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<tr>
<td><strong>Recommendation</strong></td>
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<tr>
<td><strong>We recommend that the service should:</strong></td>
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<tr>
<td><strong>a</strong> review and update its website to reflect the increase in beds and develop the website to give more information to potential patients and their families (see page 9).</td>
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National Care Standards – Independent Hospitals (Standard 3 – before you come into hospital)

<table>
<thead>
<tr>
<th>Quality Statement 1.6</th>
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<tr>
<td><strong>Requirements</strong></td>
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<tr>
<td>None</td>
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<tr>
<td><strong>Recommendations</strong></td>
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<tr>
<td><strong>We recommend that the service should:</strong></td>
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<tr>
<td><strong>b</strong> provide patients with information about what to do in case of a fire (see page 12).</td>
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National Care Standards – Independent Hospitals (Standard 15 –your environment)

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<table>
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<td><strong>c</strong> review the smoking areas to ensure that appropriate fire safety equipment is located adjacent to the area (see page 13).</td>
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</table>

National Care Standards – Independent Hospitals (Standard 15 –your environment)
### Quality Statement 2.2

**Requirements**

None

**Recommendations**

We recommend that the service should:

<table>
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<th>d</th>
<th>carry out portable appliance testing on all portable electrical appliances (see page 14).</th>
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National Care Standards – Independent Hospitals (Standard 15 – your environment)

<table>
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<th>e</th>
<th>identify all clinical hand wash basins and assess them based on current guidance. The clinical hand wash basins that are not compliant with current standards should be upgraded in line with a risk-based plan that takes into account both the use of the basin and its design (see page 14).</th>
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National Care Standards – Independent Hospitals (Standard 13 – prevention of infection)

### Quality Statement 4.4

**Requirement**

The provider must:

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<th>1</th>
<th>ensure that all staff receive regular performance review and appraisal (see page 18).</th>
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Timescale – by 17 July 2015

*Regulation 12(c)(i) Staffing*

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

National Care Standards – Independent Hospitals (Standard 10 – staff)

**Recommendation**

We recommend that the service should:

<table>
<thead>
<tr>
<th>f</th>
<th>ensure that when audits are carried out, action plans are developed in response to issues identified and that these are kept up to date to show progress (see page 18).</th>
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National Care Standards – Independent Hospitals (Standard 12 – 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>
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<tbody>
<tr>
<td>30/07/2013 and 09/08/2013</td>
<td>Not assessed</td>
<td>3 - Adequate</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>4 - Good</td>
</tr>
<tr>
<td>20/03/2014</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>Not assessed</td>
<td>4 - Good</td>
<td>4 - Good</td>
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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:

- 6: excellent
- 5: very good
- 4: good
- 3: adequate
- 2: weak
- 1: unsatisfactory

We do not give one overall grade for an inspection.

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

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

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

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

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

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare 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>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>provider</td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td>service</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.