Unannounced Inspection Report: Independent Healthcare

The Priory Hospital Glasgow | Priory Healthcare Limited
10–11 June 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
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1 A summary of our inspection

About the service we inspected

The Priory Hospital Glasgow is a private psychiatric hospital registered to provide nursing care for up to 42 inpatients and up to 40 day patients. The building is situated within a quiet residential area, close to public transport and local amenities.

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 The Priory Hospital Glasgow on Tuesday 10 June and Wednesday 11 June 2014.

The inspection team was made up of two inspectors: Gareth Marr and Winifred McLure.

We assessed the service against all 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: 6 - Excellent
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: 6 - Excellent
Quality Theme 4 – Quality of management and leadership: 5 - Very good

The grading history for The Priory Hospital Glasgow 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
- the self-assessment
- any notifications of significant events, and
- the previous inspection report of 3 and 4 December 2012.

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

- patient care records
- prescriptions
- minutes from relevant meetings
- relevant policies and procedures
• audits
• risk assessments
• staff recruitment files, and
• incident and complaints logs.

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

• patients
• the registered manager
• the clinical services manager
• ward managers
• staff nurses
• healthcare support workers
• housekeeping staff, and
• maintenance staff.

We inspected the following areas:

• bedrooms
• bathrooms
• patient lounges
• restaurant
• the medication storage area, and
• gardens and outside space.

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

• Patients are treated with dignity and respect.
• Robust processes are in place to make sure staff are recruited safely.
• Systems are in place to make sure that patient identifiable information is treated confidentially.
• Robust systems are in place to identify and manage risk.

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

• Clinical equipment should be serviced and calibrated appropriately.
• Staff should have periodic competency checks when they are administering medication.

This inspection resulted in no requirements and three recommendations. See Appendix 1 for a full list of the recommendations.

We would like to thank all staff at The Priory Hospital Glasgow 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 3–4 December 2012

Recommendation

_The Priory Hospital Glasgow should consider accessibility to their literature for people who may require the information in a different format, so that it meets the different needs of people who use the service._

Action taken

We saw the service has reviewed information it provides both in hard copy and on its website. Patients are able to access information in different formats if required. This recommendation is met.

Recommendation

_The Priory Hospital Glasgow should review their information sources for people who use the service and ensure that the correct information is provided about the regulator._

Action taken

We saw information given to patients includes the correct contact details for the regulator. This recommendation is met.
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.3
We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).

Grade awarded for this statement: 6 - Excellent
We saw that policies and procedures are in place to guide staff on how they should obtain consent to treatment. The service has developed a local policy which takes into account the differences between Scottish legislation and the legislation that is referenced in the original policy.

A policy is in place to guide staff on the use of the Adults with Incapacity (Scotland) Act 2000. This is important as this is different to the Mental Capacity Act 2005 which is used in most other parts of the Priory Group and is referenced in most of the policies relating to consent.

We looked at a sample of patient care records. We saw that in all of these records, patients had signed a consent form to acknowledge that their treatment plan had been explained to them and that they gave consent to receive this treatment. The service carries out audits of the completion of consent forms. This is done at ward level and also as part of the wider documentation audits carried out by the provider of the service.

When patients are detained under the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003, safeguards are in place to make sure that patients are given appropriate treatment whether they are able to consent to this or not. To demonstrate that these safeguards are in place, the appropriate forms should be completed and held within the patient’s care record and with their medication prescription. The information on the form should be consistent with what is prescribed for the patient. We looked at the prescription sheets for 14 patients in the service. We saw that, where appropriate, the correct forms were in place to show that either the patient had given consent or that the proper assessments had been carried out to give treatment without their consent. The information on the forms reflected what had been prescribed for the patients. We saw that the service audits the completion of these forms. The result from the most recent audit shows 100% compliance with completion of the forms.

■ No requirements.
■ No recommendations.

Quality Statement 0.4
We ensure that information held about service users is managed to ensure confidentiality and that the information is only shared with others if appropriate and with the informed consent of the service user.

Grade awarded for this statement: 6 - Excellent
Policies and procedures are in place to guide staff on how they should share information and how they should maintain confidentiality.

Local policies and procedures are in place to guide staff on how to send information using electronic systems such as email and fax machines. There are also local policies to guide
staff on what information can be shared with different groups of people, for example GPs or insurance companies.

We saw that when patients are admitted, they complete forms to indicate who can be given information about them. This includes family members, carers and professionals, such as their GP. The form also indicates what information can be given to specific people. For example, patients can give consent for all aspects of their care and treatment to be discussed, while others may only give consent for limited information to be given.

During the inspection, we saw that patient information is stored appropriately. Hard copies of patient care records are kept in rooms which are locked when no one is using them. The service also has an electronic patient record which is accessed through a password protected system. Only authorised staff have access to this system. We did not see any patient identifiable information being stored or left in inappropriate places during the inspection. We did not hear staff having conversations about confidential patient information where it could be overheard by other patients, visitors or others who did not need to know the information.

■ No requirements.
■ No recommendations.

Quality Theme 1 – Quality of care and support

Quality Statement 1.4

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

Grade awarded for this statement: 5 - Very good

We looked at 14 prescription sheets during the inspection. We found that all the prescriptions had:

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

We looked at the recording sheets that corresponded to these prescription sheets. We saw that these had all been completed appropriately with no gaps in the recording.

We also saw evidence that a pharmacist reviews all prescriptions within the service and makes any recommendations about any necessary changes. The pharmacist also monitors that the administered medication is recorded correctly.

A policy is in place for staff to follow if they make a medication error. Staff we spoke with were able to tell us what they would do if they made an error, including seeking immediate medical advice if necessary.
Medication was stored securely in the service. Controlled drugs are also stored appropriately. Controlled drugs are medications that require to be controlled more strictly, such as some types of painkillers. The service carries out twice daily checks of the stock levels of controlled drugs.

While the service rarely uses rapid tranquilisation, a policy is in place to support this. Rapid tranquilisation is used when staff have to give people medication to sedate them in an emergency situation. The policy sets out the process staff should follow if they have to sedate people. The policy outlines the need for continued physical monitoring of the person for a period after the medication has been given.

Some of the patients who are admitted to the Priory Hospital will be supported to undergo detoxification. These patients may be prescribed medication to help them manage the physical symptoms of their withdrawal. We saw that the service carries out regular routine physical observations during the detoxification process. This includes monitoring the patient’s blood pressure, pulse and temperature. Patients are also given a full physical examination by a doctor when they are admitted. This includes an electrocardiogram (ECG). This is a test that shows how well a person’s heart is working.

The service carries out regular medication audits. We reviewed the audit that was carried out in April 2014 looking at the previous three months prescribing. This showed some areas for improvement. We saw that an action plan was put in place. The action plan detailed what actions should be taken, who was responsible and the timescale for completion. Further audits will be carried out to check if improvements have been made.

**Areas for improvement**

While we saw that the service regularly monitors the physical health of patients who are undergoing a detoxification process, the service does not routinely use a recognised withdrawal rating scale. A withdrawal rating scale is a tool used to help measure the severity of withdrawal symptoms the patient is experiencing. During the inspection, we were told that the service is currently choosing an appropriate rating scale to use (see recommendation a).

While we saw that staff are given training on medication management, they do not routinely have their practice observed. It is good practice to periodically observe the practice of staff who are administering medication. This ensures they are administering medication safely and are following best practice guidelines (see recommendation b).

- No requirements.

**Recommendation a**

- We recommend that the service should ensure that patients undergoing detoxification are regularly assessed using a recognised withdrawal rating scale.

**Recommendation b**

- We recommend that the service should ensure that all staff who administer medication have their practice observed periodically to ensure that they are administering the medication safely.
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: 6 - Excellent

We looked at risk assessments that are completed for individual patients. The risk assessment covers areas such as risk of:

- suicide
- deliberate self-harm
- absconding
- harming others
- self-neglect, and
- withdrawal.

The risk assessments look at the current risk and also any previous history of risk. We looked at the records of one patient who was assessed as being high risk. We saw that the risk assessment had been regularly updated and the levels of risk re-assessed.

All patients are assessed for any risk when they are discharged from the service. They are also given details of who they should contact if they have a period of crisis following their discharge. We saw that the service carries out regular audits of the completion of risk assessments. The most recent audit shows 100% compliance with the completion of risk assessments on admission.

When patients are assessed as being high risk, they may be placed on enhanced levels of observations. This may mean that they are accompanied by a member of staff at all times. We saw that the service has a policy to guide staff on how they should support patients who are on enhanced levels of observation. There is also a local policy to reflect the differences with the way enhanced observations are carried out in Scotland.

We saw that there are three anti-ligature rooms in the service. These are located next to the nurses’ station. Anti-ligature rooms are bedrooms that have been adapted to reduce the risk of patients being able to self harm. We were unable to look at these rooms during the inspection as patients were using them. However, the service has carried out risk assessments of all the bedrooms in the service including the anti-ligature rooms.

We looked at the service’s risk register. This identifies areas of risk along with how the risk is currently being managed. It also outlines what work will be carried out to try to reduce the risk further.

When there are any serious incidents in the service, we saw that it carries out a serious untoward incident review (SUI). An SUI review is carried out when there has been a significant event which has led to serious harm or potential serious harm to a patient. We looked at examples of SUI reviews that had been carried out. These detailed what had happened, the circumstances leading up to the incident and any learning that could help reduce the risk of a similar incident occurring in the future.
We saw that each department in the service has a risk assessment which looks at the risks relevant to their department. This includes any environmental risks. All the control of substances hazardous to health (COSHH) risk assessments were up to date.

- No requirements.
- No recommendations.

Quality Theme 2 – Quality of environment

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
The service is provided in two large converted houses, one of which has been extended and provides the majority of the patient accommodation.

The accommodation was in good decorative order throughout. The majority of the furniture was in good condition. We saw that a high standard of cleanliness was maintained. Patients have the use of a variety of areas such as:

- large rooms for group work
- individual therapy rooms
- patient lounges
- quiet areas
- art room
- games room
- laundry
- kitchen, and
- restaurant.

All bedrooms are single and have en-suite shower and bath facilities. The bedrooms we looked at were in good condition and were all clean. The service has recently started to look after a patient group with different needs where there will be a focus on rehabilitation. We saw one area of the hospital had been adapted to support this. The patient in this area had an en-suite bedroom and also had a private lounge with a small kitchen.

We looked at the feedback given by patients in the satisfaction surveys carried out in 2013. The feedback showed a high level of satisfaction with the quality of the accommodation.

We saw that established systems are in place for reporting and dealing with maintenance issues. Staff we spoke with told us that systems work well and that maintenance issues are dealt with quickly.

- No requirements.
- No recommendations.
Quality Statement 2.3

We ensure that all our clinical and non-clinical equipment within our service is regularly checked and maintained.

Grade awarded for this statement: 5 - Very good

We saw that systems are in place to make sure that all clinical and non-clinical equipment within the service is regularly checked and maintained. We saw service records for both clinical and non-clinical equipment, including equipment serviced by outside contractors.

Processes are in place to report and record any issues with equipment. We were told how any issues were then dealt with. All staff we spoke with knew how to report issues with equipment. Patients are also given this information to allow them to report any issues that they become aware of.

We checked a sample of clinical and non-clinical equipment in the service. We saw that most were being checked and serviced on a regular basis. Some equipment such as weighing scales and the alcohol breathalyser are important due to the nature of care some patients require. We saw that these were checked and calibrated once a week.

Area for improvement

While we saw that the majority of equipment we looked at had been checked, some clinical equipment was not being regularly checked or calibrated. This included a blood glucose monitor and a blood pressure monitor (see recommendation c).

- No requirements

Recommendation c

- We recommend that the service should ensure that all clinical equipment in the service is regularly checked and calibrated to ensure that they are giving an accurate reading.

Quality Theme 3 – Quality of staffing

Quality Statement 3.2

We are confident that our staff have been recruited and inducted, in a safe and robust manner to protect service users and staff.

Grade awarded for this statement: 6 - Excellent

We saw that policies and procedures are in place to support safe recruitment in the service. We were told that the administration processes for recruitment are now managed centrally in the organisation.

We looked at four recruitment files chosen at random. The files were in good order and easy to follow. All the files we looked at included:

- role descriptions
- health declaration
We saw that systems are in place to check that staff within the service have maintained registration with the relevant professional body. Healthcare staff have to fulfil certain criteria to remain on their professional register, for example nurses must be registered with the Nursing and Midwifery Council to continue to practise. The service carries out these checks annually.

We saw evidence of checks including retrospective checks for staff through the new PVG scheme.

An induction programme is in place within the service. The induction programme includes time for online and face-to-face learning. It also includes a period when new staff work on a supernumerary basis. This means they are able to work without being counted in the normal number of staff who would cover the shift. This allows them to work closely with experienced colleagues and learn about how the service runs. All staff spoke positively about the induction process. They told us they felt the induction process had prepared them for the role they were asked to perform.

- No requirements.
- No recommendations.

**Quality Statement 3.4**

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

Grade awarded for this statement: 6 - Excellent

Staff we spoke with during the inspection told us they feel they are treated with respect. They told us the different teams in the service all work well together. They felt valued and well supported by colleagues, senior staff and the management team. They also spoke positively about their working environment. They told us there was an open culture in the service where they felt able to challenge colleagues if necessary. Staff told us: ‘Senior staff and managers are visible and very approachable.’

Staff spoke positively about the people who use the service. Staff felt as if they were part of a community, for example they eat with people who use the service.

A whistle blowing policy is in place in the service. This sets out how staff can bring any areas of concern to the attention of senior staff. While none of the staff we spoke with had ever had concerns with how patients were treated, they were aware of the whistle blowing policy and felt able to use it if necessary. We also saw that leaflets are available in different places throughout the hospital with contact details for the service’s safeguarding officer. This gave details of who patients, staff or visitors should contact if they thought anyone was at risk of harm.
We looked at the results from patient satisfaction surveys carried out at different times during 2013. The results showed that 100% of patients who completed the survey felt they were treated with dignity and respect at all times.

We spoke with patients during the inspection. They told us there is always a member of staff to speak with and that staff will make time for them. They told us they felt they are treated with respect. They did not have any concerns about the way staff spoke to them. They told us: ‘Staff are brilliant, really patient centred and very patient.’

During the inspection, we saw many examples of staff and patients interacting in a positive manner. Staff and patients appeared to know each other well and had good relationships. Staff spoke with patients in a supportive and respectful manner.

- No requirements.
- No recommendations.

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

**Quality Statement 4.3**

To encourage good quality care, we promote leadership values throughout our workforce.

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

We saw an organisational chart in the service that clearly defines the areas of responsibility for each staff member. Staff we spoke with were clear on their place within the organisational structure and the responsibilities they had.

Staff have an annual appraisal. Part of the appraisal process is for staff to self assess their own performance. Staff are expected to identify their own learning needs and to create a plan for future professional and personal development.

Clinical supervision takes place monthly. This can either be one to one supervision or group supervision. The emphasis in supervision is for the staff member to take responsibility for identifying professional or personal issues to be discussed.

We saw that staff take active leadership roles within the areas that they are responsible for. We saw several examples where staff had made changes and put in place systems and processes to assure the quality of care or service their department provides. Staff told us they felt able to make changes in their areas and that senior management supported them to do this.

Online learning is available through Foundations for Growth and group or one to one teaching sessions within the hospital. Staff can also apply for additional or other courses outwith the organisation, relevant to their practice and subject to approval.

There is a focus on promoting positive relationships within the service. Staff we spoke with told us they felt that communication in the service was good. They told us they felt comfortable raising any issues or making suggestions for improvement.

- 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 saw a clinical governance framework is in place in the service. This includes:

- monthly clinical governance meetings
- clinical audit committee meetings, and
- senior management team meetings.

We looked at the minutes from the clinical governance meetings held in March and April 2014. The minutes show that outstanding actions from previous meetings are discussed. The minutes also show if these actions have been completed or have been carried forward. The person responsible for completing the actions is clearly identified. We saw various topics are discussed such as:

- adult protection issues
- infection control
- health and safety
- service user feedback
- complaints
- risk assessment and care planning, and
- incidents.

Actions are clearly detailed along with the person responsible for completing them and the expected timescale. We saw evidence of detailed discussion about a number of incidents involving a specific patient. The discussion considered any ways that the service could adapt to reduce the number of incidents or if the placement within the service was currently suitable.

We looked at the minutes from the clinical audit committee meeting held in May 2014. The minutes show that all recent audit activity in the service is discussed. Any areas of non-compliance are identified and actions put in place to make improvements. The person responsible for completing the action and the timescale for completion is clearly identified. All outstanding actions from previous meetings are discussed. We also saw from the minutes that the committee reviews incident forms. They discuss the actions that were taken at the time to make sure these were appropriate. They also consider if any further actions can be taken to reduce the risk of a re-occurrence of similar incidents.

There are also clinical governance structures within the wider organisation (Priory Healthcare Limited) that is responsible for providing the service. This includes analysis of a wide range of data on areas such as:

- completion of audits
- completion of electronic patient care records
- recent inspection activity of all services in the group
- complaints, and
• incidents.

The data is then shared with all services within the Priory Group. This allows services to see how they are performing against similar services. They can also look at any risks or areas of improvement that have been identified in similar services. This allows them to consider if they have to look at managing these risks or making these improvement in their own service.

The service carries out a variety of audits throughout the year. Audits include:

• medication
• use of restraint
• infection control
• preventing suicide
• adult protection, and
• patient care records.

We saw evidence of improvement action plans being put in place to address any areas of non-compliance.

We looked at the complaints log for the previous 6 months. We saw that all complaints had been fully investigated and resolution letters sent to the person who made the complaint. We saw evidence that the service was using the complaints process to identify areas where they could make improvements.

We saw that the service uses patient feedback to make improvements. Examples include:

• refurbishing the smoking area
• having a member of therapy staff on duty at the weekend
• organising access to the local gym for patients who are able to use it, and
• putting a greenhouse in the garden.

■ 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 1.4

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### Quality Statement 2.3

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**Appendix 2 – Grading history**

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<th>Quality of information</th>
<th>Quality of care and support</th>
<th>Quality of environment</th>
<th>Quality of staffing</th>
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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](http://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>
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<tr>
<td>6</td>
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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>
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<tbody>
<tr>
<td><strong>provider</strong></td>
<td>A provider is an individual, partnership or business that delivers and manages a regulated healthcare service.</td>
</tr>
<tr>
<td><strong>service</strong></td>
<td>A service is the place where healthcare is delivered by a provider. Regulated healthcare services must be registered with Healthcare Improvement Scotland.</td>
</tr>
</tbody>
</table>
We can also provide this information:

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