Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
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1  A summary of our inspection

About the service we inspected

The Huntercombe Services - Murdostoun Brain Injury Rehabilitation Centre is registered with Healthcare Improvement Scotland as an independent hospital. The hospital provides specialist assessment and rehabilitation healthcare services to people aged 16 years and above with a brain injury or other complex neurological conditions.

Located within the grounds of Murdostoun Castle near Newmains, the hospital is a single storey building with single room accommodation. Healthcare services are provided for up to a maximum of 21 people.

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 Murdostoun Brain Injury Rehabilitation Centre on Tuesday 5 and Wednesday 6 April 2016

The inspection team was made up of two inspectors, Karen Malloch (lead inspector) and Roy Young.

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**: 3 - Adequate
- **Quality Theme 3 – Quality of staffing**: 3 - Adequate
- **Quality Theme 4 – Quality of management and leadership**: 4 - Good

The grading history for Murdostoun Brain Injury Rehabilitation Centre and more information about grading can be found on our website.

Before the inspection, we reviewed information about the service. During the inspection, we gathered information from a variety of sources. We spoke with a number of people during the inspection.
What the service did well

- The service has shown improvement since the last inspection and has addressed 14 of the 15 recommendations. We found that the service provided prospective patients and families with a very good level of support and advice prior to admission and the families we spoke with gave very positive feedback on their experience.
- The service’s electronic care record system had improved the care planning process and recording patient care. Notes were also more accessible to staff.
- We saw good communication between the care, nursing, medical and therapy staff. We saw individual patient’s wishes were given consideration, along with any risks that may impact on their wellbeing.
- The quality assurance system is developing and we saw that the service used feedback to improve the quality of care.

What the service could do better

- The service could review their publications to ensure they are up to date and make sure that information regarding the complaints process is included.
- Improvements must be made to the recruitment processes. Assurance should be provided that staff are fit to be employed in the service.
- Some areas of the internal and external environment require upgrading. The service should be more accessible to patients with limited mobility.
- A more structured approach to the infection prevention and control system is needed and action plans should be developed for audits where gaps in good practice have been identified.

This inspection resulted in four requirements and 14 recommendations. See Appendix 1 for a full list of the requirements and recommendations.

Four Seasons Health Care Properties (Frenchay) Limited the provider, must address the requirements and the necessary improvements made, as a matter of priority.

We would like to thank all staff at Murdostoun Brain Injury Rehabilitation Centre for their assistance during the inspection.
2 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 8 April 2015

Requirement

Ensure that the care planning process includes how all the identified care needs of a client are to be met. This should include their psychological, social and spiritual needs.

Action taken

The service introduced an electronic care record system in June 2015. We looked at patients’ care plans and saw that these addressed patients assessed needs and included recognition of their psychological, social and spiritual needs. This requirement is met.

Requirement

Ensure that each person employed in the provision of the independent healthcare service receives regular supervision, performance review and appraisals.

Action taken

This requirement is reported under Quality Statement 3.3. This requirement is not met (see requirement 4).

Requirement

Ensure that any treatment or services provided by the service are of a quality which is appropriate to meet the needs of the patient. To do this, the provider must develop a system of clinical governance that gathers information from feedback and reporting mechanisms and uses this information to measure and improve the quality of the service provided.

Action taken

This requirement is reported under Quality Statement 4.4 This requirement is met.

Requirement

The service must ensure that there are appropriate systems and processes in place for all aspects of care and treatment including infection control. To do this, the provider must:

(a) undertake a review of infection control management within the service including policies and procedures
(b) undertake a risk assessment of each area
(c) implement a regular audit system
(d) review staff training, and
(e) review provision of staff hand washing facilities

Action taken

This requirement is reported under Quality Statement 2.4 This requirement is not met (see requirement 2).
Requirement
Ensure that the premises are suitable for the client group. To do this, the provider must ensure that the building and external areas are accessible and safe.

Action taken
This requirement is reported under Quality Statement 2.2. This requirement is met.

What the provider had done to meet the recommendations we made at our last inspection on 8 April 2015

Recommendation
We recommend that the service should update its website to be clear about how to make a complaint about this service in Scotland. Reference to the Parliamentary and Health Service Ombudsman should be removed as it is for English services.

Action taken
The service has updated the website to include clear information on how to make a complaint to Healthcare Improvement Scotland. This recommendation is met.

Recommendation
We recommend that the service should finalise the participation policy, including how feedback is provided to clients and relatives about changes made following suggestions they have made.

Action taken
The participation policy has been finalised and systems are in place to ensure feedback is gathered and fed back to improve service provision. This recommendation is met.

Recommendation
We recommend that the service should seek feedback more actively from clients and relatives, and develop methods of gaining feedback that are as inclusive as possible for clients with physical and/or cognitive impairment.

Action taken
This recommendation is reported under Quality Statement 1.1. This recommendation is met.
Recommendation
The service should ensure that clients who are away from the service on leave have their medication management needs recorded and clarified with their carers to ensure safety.

Action taken
The service had put effective systems in place to ensure patient medication requirements while on leave are assessed, recorded and communicated to families and carers. This recommendation is met.

Recommendation
The service should ensure staff have the training and facilities to support clients with self-medication whenever possible as part of their goal-focused rehabilitation plan.

Action taken
The service’s current policy is that patients do not self-medicate. This is due to patient profile and the lack of facilities and trained staff available to support this. This service has chosen not to implement this recommendation.

Recommendation
The service should ensure that clinical and therapy staff develop an effective team approach in delivering care to clients.

Action taken
The multidisciplinary meeting convenes weekly and includes medical staff, psychiatrist, therapy staff, nurses and carers. Patients care is discussed and care is planned by the team. Integrated care planning has been developed through the implementation of the electronic care records system. This recommendation is met.

Recommendation
The service should undertake an audit of the environment to identify any works that require to be carried out. The provider should then establish an action plan to ensure the necessary works are undertaken.

Action taken
An audit and action plan have been completed. This recommendation is met.

Recommendation
The service should establish a risk register to identify the different risks in the service and how these risks will be managed.

Action taken
A risk register is now in place and is review through the clinical governance meetings. This recommendation is met.
Recommendation
The service should ensure that there is adequate extraction in the designated smoking lounge.

Action taken
The service has now removed the internal smoking area. **This recommendation is met.**

Recommendation
The service should ensure copies of certificates are requested at the point of recruitment and copies retained in staff personnel files.

Action taken
This recommendation is reported under Quality Statement 3.2 **This recommendation is not met** (see requirement 3).

Recommendation
The service should develop an action plan to address the need for nurses to have training in rehabilitation.

Action taken
The service has been unable to source specific rehabilitation training. This is reported under Quality Statement 3.3. **This recommendation has been reviewed and changed** (see recommendation k).

Recommendation
The service should consider the appointment of a discharge co-ordinator or social worker to meet the minimum staffing guidance as set out by the British Society of Rehabilitation Medicine.

Action taken
The service has appointed a discharge coordinator a structured discharge process has now been implemented. **This recommendation is met.**

Recommendation
The service should review the provision of meals and snacks to ensure that this meets with best practice. The menu should be nutritionally analysed to ensure a balanced diet that includes a minimum of five portions of fruit and vegetables each day.

Action taken
The menu is reviewed by a dietician to ensure appropriate nutritional value for patients in line with nutritional care standards. **This recommendation is met.**
**Recommendation**

The service should put systems in place so that staff interactions with clients can be monitored.

**Action taken**

From a review of management structures charge nurses and senior support workers are now in both wards. Management have a visible presence on the floor and undertake observations of staff practice. **This recommendation is met.**
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.2
We provide full information on the services offered to current and prospective service users. The information will help service users to decide whether our service can meet their individual needs.

Grade awarded for this statement: 5 - Very good

The service has a dedicated website with a range of information for patients and families. You can find the service website here:


The website also had a link to the latest inspection reports.

We spoke with five patients’ families about the quality of information provided. They told us that doctors or consultants from the community hospital the patients were first admitted to had given them initial information and referred them to the service.

Once the referral was made, the patients and their families received a visit from staff at the service. Family members told us this was a great help in answering their questions. They also praised staff’s manner during re-admission assessments as ‘informative, thoughtful and considerate’. Patients and families were also encouraged to visit the service before their admission.

A brain injury awareness group for patient families and carers met every 3 months. The people we spoke with who had attended this group found it helped raise their awareness of the issues associated with brain injury and manage their own expectations of recovery.

The service’s admission pack for new patients and their families had general information for patients, such as meal times, smoking policy and visiting times. The service was reviewing the admission pack for patients and welcome pack for families and carers.

Areas for improvement
The admission information pack and a ‘Your guide Murdostoun’ talked about both brain injury units at the service. One of these brain injury units is regulated by the Care Inspectorate. It would benefit prospective patients, families and carers to receive information about each unit separately to avoid confusion.

The admission information pack and ‘Your guide to Murdostoun’ contains no mention of Healthcare Improvement Scotland as the service’s regulator, or that complaints can be made directly to Healthcare Improvement Scotland (see requirement 1).

Requirement 1– Timescale: by 1 June 2016

■ The provider must update the patient information to make it clear to the complainant that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process.

■ No recommendations.
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: 4 - Good

The service had policies and procedures to manage consent in place. A doctor assessed all patients’ ability to give consent to treatment on admission. The service could follow a legal process to allow doctors and other staff to provide the care and treatment needed if a patient was unable to give consent. The five patient records we saw had completed capacity certificates.

Consent was discussed as part of patient reviews during a multidisciplinary team meeting we attended during the inspection. We observed interactions between staff and patients and saw that staff would explain and consult with patients before any activity or care.

Patient families and carers told us that patients had made good progress while in the service. They felt involved and consulted about patient care.

Areas for improvement
Consent should be an ongoing process between nursing staff and patients, rather than something that is asked once. Not all staff we spoke with were aware of this (see recommendation a).

- No requirements.

Recommendation a
- We recommend that the service should provide consent training for staff to improve awareness.

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: 4 - Good

The service used a wide variety of methods to gather feedback from patients, families and carers, such as the annual survey and ‘your say’ meetings.

Two members of staff organised the your say meetings. These meetings were held regularly and offered patients the opportunity to share their thoughts on patient experience. Actions from these meetings were completed and the outcomes fed back to patients. Agendas we saw for the meetings showed patients had been consulted and influenced the quality of service.

Minutes of the your say meeting showed open dialogue between staff and patients. From action plans and outcomes, we saw strong evidence that if an issue was not resolved quickly it was not allowed to slip off the agenda. For example, patient dining experience was first
raised in September 2015, fed back in October 2015 and eventually resolved in November 2015 when mealtimes changed to better suit patient routines. Each patient had a key worker and a named nurse who verbally asked for feedback from patients and their families.

The service manager had an open-door policy and met with patients and carers or families every 3 months. Clinical psychologists were available to meet with patients and families one evening each week.

We observed that the patient experience was open to choice. This was evident at meal times where the patients were able to express their preference and choose from the food offered.

The provider completed an annual patient survey that asked about their daily living experience. Staff or family members could help patients to complete this and it had a 74% return rate. The completed surveys showed that opinion varied, but overall feedback had improved on previous results.

The service had recently introduced two short, tablet computer-based ‘family and friends tests’; one for patients and the other for family and friends. Questions included ‘Do you feel safe?’ and ‘Do staff treat you with respect?’ The service hoped this would provide immediate, user-friendly feedback.

The service planned to introduce patient-led assessments of the environment and exit questionnaires.

**Areas for improvement**

The service’s current patient and family satisfaction surveys covered the two Murdostoun campus units. The surveys would benefit from treating each unit separately. This would allow each unit to target its own areas to improve (see recommendation b).

In its self-assessment, the service stated that patients could be involved in staff recruitment by submitting interview questions or meeting the candidates. However, patient survey results identified this as an area for improvement. Management staff planned to put processes in place to support participation.

- No requirements.

**Recommendation b**

- We recommend that the service should separate patient survey results to ensure feedback is unit specific.

**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 had systems and processes in place to identify and manage risk. All patients were assessed before admission to make sure the service could meet their care needs. A risk inventory was completed with all patients, and this looked at vulnerability and a range of negative behaviours relating to violence and self-harm.
The five patient care records we saw had completed risk assessments and had been discussed with patients, their families and carers where possible. They covered clinical issues such as pressure area care and activities such as using the hydrotherapy pool.

The multidisciplinary meeting discussed clinical health risks and used this information to plan care. Patients were discussed daily at handover meetings, including addressing the changes in risk to patients. Staff we spoke with showed awareness of balancing risk and promoting independence.

Accidents and incidents were reported through an electronic system and discussed at the clinical governance meeting. Staff we spoke with knew how to report accidents and incidents. A risk register had been put in place since our last inspection and was reviewed regularly. The provider had a range of policies and procedures in place to manage risk.

We saw that staff had received training in managing violence and aggression, and other mandatory requirements in training included moving and handling and fire safety.

Risk management was a routine part of the provider’s governance process. Lessons learned through incidents were shared across all its services.

**Areas for improvement**

Staff had limited understanding of adult support and protection procedures. Management staff told us this would be included in the service’s new induction programme (see recommendation c)

The new electronic care record system frequently lost its connection. Without this connection, staff could not access patient notes to find information regarding care or record information. Staff told us this was an ongoing issue and had a potential to impact patients if the system went down for longer (see recommendation d).

- No requirements.

**Recommendation c**

- We recommend that the service should ensure all staff receive training in adult support and protection procedures.

**Recommendation d**

- We recommend that the service should review provision of electronic care records and ensure consistency of performance and staff access.
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: 4 - Good

The service was made up of single storey accommodation; two ward areas and a self-contained flat for promoting independent living. Facilities for patients included a hydrotherapy pool and a therapy kitchen. A maintenance system was in place and the team responded to requests from staff and managed various contractors. Maintenance records showed requests were addressed promptly.

The service’s communal areas were spacious with wide corridors. This made movement around the building easy, particularly for patients using mobility equipment.

Only four patient rooms had ensuite facilities. This meant patients shared toilet bathroom facilities, which could have affected their privacy. Although the environment was sparsely decorated, patients were able to personalise their rooms.

Improvements had been to the building since our last inspection, including:

- bedroom carpets replaced with hard flooring
- ceiling hoists installed in three rooms
- hydrotherapy pool repaired
- shower room refurbished, and
- toilets upgraded.

Further planned improvements included changing the main door to give patients who like to sit in this area more privacy. The service also planned to redesign the nurses station to improve the confidentiality of patient information.

To help make the building safe and secure, a closed circuit TV system monitored the front door and other common areas and visitors signed in and out. A nurse call system had also been installed. We observed staff responding quickly when patients pressed the bell for assistance.

Areas for improvement
At our previous inspection, we required the provider to ensure premises were suitable for the client group. While there have been many internal improvements, front door accessibility was still an issue. Families and staff told us that manoeuvring wheelchairs into the service was difficult. Families also confirmed they were restricted in their ability to take their relative outside for a walk when visiting (see recommendation e).

We saw a large collection of cigarette ends lying on the ground or deposited in an overflowing pot at the front entrance. This was unsightly and staff should direct patients away from the front door and to use the smoking shelter provided when smoking.
The domestic services room needed to be refurbished. Plaster and pipes needed attention and shelving should be reviewed and positioned to ensure they are at a safe workable height for staff. An appropriate, dedicated sink to empty dirty water should be installed (see recommendation f).

One bath surround wood was damaged and could pose a risk to patients. Management told us that this bath was not in use. However, this should be de-commissioned or repaired (see recommendation g).

- No requirements.

**Recommendation e**

- We recommend that the service should make improvements to the external front entrance of the building to ensure patient safe access and egress.

**Recommendation f**

- We recommend that the service should upgrade the domestic service room to ensure its safe and fit for purpose. Including the installation of a suitable sink for disposing of dirty water. *Scottish Health Technical Memorandum 64: Sanitary Assemblies* (December 2009).

**Recommendation g**

- We recommend that the service should ensure the bath and surrounds are repaired and safe for patient use or the bath decommissioned and removed.

### 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: 3 - Adequate**

A charge nurse had been designated lead for infection control. However, they were not present on the days of the inspection and this impacted on our ability to inspect against this quality statement.

We found that staff generally were aware of good infection control practice. We found systems in place to manage waste and disposal of sharps.

We saw that procedures were followed in managing laundry, soiled linen was laundered using water soluble bags to minimise contamination, and a clear flow for processing dirty laundry was in place.

We saw that the service was clean. We spoke with housekeeping staff and saw domestic cleaning schedules were in place. The domestic supervisor signed these each month and staff confirmed they signed jobs off when completed.

To assure the quality of cleaning, a monthly audit was carried out and issues identified were discussed with staff. A system was in place to make sure bedrooms were cleaned thoroughly when a patient occupying the room had been discharged.
There was adequate provision of alcohol-based hand gels for staff and hand washing signage to prompt good practice. Staff confirmed that enough personal protective equipment was in stock.

**Areas for improvement**

We saw that some aspects of this requirement had been actioned. NHS Lanarkshire had carried out a risk assessment and identified some areas for improvement. The infection control audit file showed audits carried out every 3 months. However, as action plans were not developed we could not verify actions had been completed. The audit process should lead to measurable improvements in staff practice and outcomes for patients.

We saw current infection control policies and procedures developed by the provider. Management staff also told us the service had adopted NHS Lanarkshire’s infection control policies and procedures. However, some policies appeared out of date. In the absence of the infection control lead, the service was unsure if the NHS Lanarkshire policies were current. The service should adopt the Health Protection Scotland’s *National Infection Prevention and Control Manual* (2015) as best practice.

We saw no evidence of infection prevention and control training and some staff were unsure if or when they had received this training. Although online learning modules were mandatory, some staff reported they had been unable to access the system to complete the module. Staff were not fully aware of who the infection control lead was or what their role included. We found a lack of clarity about their role and responsibilities (see requirement 2).

We saw a build-up of dirty laundry bags in the laundry room encroaching on the clean area. One washing machine was out of order and impacted on the laundry efficiency. The laundry for both services on the campus was based on this site. The design of the laundry did not include storage for excess dirty linen (see recommendation h).

We were told the service had bought some equipment for staff hand hygiene training and monitoring. The service should implement a system to regularly monitor hand hygiene practice (see recommendation i).

The service’s vacuuming equipment was dated. The service could review its vacuuming equipment to make sure equipment complies with the three-stage filtration in patient areas in line with national cleaning services specification.

We looked at sharps management and saw that staff were not using the temporary closure for the sharps bins or completing the sharps bin labels in line with guidance.

**Requirement 2 – Timescale: by 1 July 2016**

- The provider must ensure that there are appropriate systems and processes in place for all aspects of care and treatment including infection control. To do this, the provider must:

  (a) ensure all staff receive training appropriate to their roles and that this is recorded and monitored
  (b) implement a robust auditing and reporting system
  (c) ensure that information in regards to infection prevention and control is current reflects best practice and is accessible to all staff. As best practice the service should adopt the Health Protection Scotland’s *National Infection Prevention and Control Manual* (2015).
Recommendation h

- We recommend that the service should review the laundry area and investigate alternative storage options for dirty laundry to avoid build up.

Recommendation i

- We recommend that the service should implement a system to regularly monitor staff’s hand hygiene practice.

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: 3 - Adequate

We checked the files of two registered nurses for registration with the Nursing and Midwifery Council. This is the organisation responsible for ensuring that all trained nurses comply with professional standards. Both files had evidence that registration had been checked.

The provider had an induction and probation policy. This tried to make sure any new member of staff had a thorough understanding of the service and their own role. Employees were expected to complete a 3-month induction and probation before being taken on permanently.

Areas for Improvement

We asked all members of staff we interviewed about training and induction. The human resource team reported that training had taken place but was not fully recorded. No annual training plan was in place.

Staff we spoke with told us they had an induction. We saw no evidence of staff induction in their files. The service manager told us the induction was being reviewed (see recommendation j).

Staff files we reviewed had no evidence of required recruitment checks. Four of the six files we looked at did not have a second reference. Only three files had a copy of the start date and confirmation letter. We saw no copies of any staff member’s qualifications. We had previously recommended that the service should make copies of staff members’ qualifications. This had not been addressed (see requirement 3).

Background checks had been carried out on all staff. We saw two Protection of Vulnerable Groups scheme membership certificates in the files. The Data Protection Act 1998 requires that personal information should be kept only for as long as it is required for the purposes for which it was obtained. These certificates should be removed, destroyed and a reference number kept on file, in line with this legislation.

Requirement 3 – Timescale: immediately on receipt of report

- The provider must not employ any person who does not have the qualifications, skills and experience necessary for the work the person is to perform. To do this the provider must ensure that a robust recruitment system is in place which includes uptake of appropriate references and confirmation of qualifications.
Recommendation j

- We recommend that the service should ensure that records are available to confirm that staff have undertaken induction to the service appropriate to their role.

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: 3 - Adequate

The mandatory training programme had 13 modules for all staff to complete yearly or every 2 years depending on the subject matter. Different grades of staff also completed additional modules applicable to their role.

Nursing staff told us they could access a range of training reflective of patients’ diagnosis and medical conditions. Recent training included tracheostomy care, and venepuncture.

Staff we spoke with felt they had lots of opportunities to develop skills. One staff member was completing a Scottish vocational qualification for health and social care. A manual handling champion had been trained so they could deliver training to staff.

Catering and maintenance staff felt very well supported and we saw that appraisals, supervision and training in this department was taking place in line with the provider’s policy.

Areas for improvement
We saw no evidence that all staff had received an annual appraisal or regular supervision (see requirement 4).

Most staff reported that they received training appropriate to their role. However, this was difficult to verify due to a lack of current training records. The service did not have a robust training programme governance. The manager told us that the provider was developing a learning academy for staff (see recommendation k).

Staff reported that the internal training sessions were not taking place regularly.

Some staff reported that they could not access the online training. Management staff told us that although the online learning system had been down, the issue had been resolved and all staff should have had access.

Some staff told us that they didn’t always feel well supported. They told us that training was available but felt it was more self-directed (see recommendation l).

Requirement 4 – Timescale: 1 July 2016

- The service must ensure that each person employed in the provision of the independent healthcare service receives regular supervision, performance review and appraisals.
Recommendation k

- We recommend that the service should ensure that robust systems are in place to record and review staff training.

Recommendation l

- We recommend that the service should review staff training with staff to ensure training delivered is appropriate to meet the needs of the service.

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: 4 - Good

The service set out clearly defined roles and staff we spoke with were clear about the responsibilities and reporting structures.

A staffing review had introduced senior support workers to bridge the gap between support workers and nurses. Staff told us this was positive and provided extra development opportunities.

The service had systems in place to recognise positive contributions from staff. We saw two employee of the month schemes where employees were nominated by colleagues or patients. Winners of the schemes were displayed on notice boards. The service also had another scheme called ‘Huntercombe hero’, where staff could be nominated for doing something above and beyond the call of duty.

The service had been approved to accept nursing students and sent staff on mentorship training to help them support students.

Both wards had charge nurses and senior staff nurses. Most staff we spoke with told us they felt supported and believed the service was well led. They told us that management staff were approachable and staff had opportunities to be involved in various project working groups.

Staff survey results from last year showed improvement in positive staff feedback in areas such as personal ownership or shared vision.

Area for improvement

During our last inspection, we were told that working relationships between clinical staff and therapy staff were strained. We saw improvement in integrated working between these two groups, for example in care planning. However, some staff still reported issues, such as in communication, between the teams. The service could consider team-building initiatives to improve relationships and support staff to identify ways to improve.

- 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: 4 - Good

The service submitted a basic 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 were able to verify the information supplied in the self-assessment, but the quality of this information was poor.

The organisation had systems in place to assure the quality of the service. The corporate clinical governance structure was implemented in 2015. Part of this was the creation of the clinical cabinet, a group of senior staff who provided clinical advice and leadership. Membership included the chief executive officer, medical director and clinical director of quality and scrutiny. Subgroups such as medication management, and training and development, fed into this.

The provider’s corporate clinical governance committee met every 2 months. Minutes showed the committee had a number of relevant standing agenda items, such as quality and safety and regulatory activity.

The service’s local clinical governance committee also met every 2 months and fed information about service performance into the corporate structure. Service performance was measured against the provider’s other services.

A new senior management meeting had been set up to provide a focus on clinical care delivery. This monthly meeting discussed clinical processes in the service. This, along with a range of other staff and patient meetings, fed back to the clinical governance structure.

The clinical governance committee minutes showed standing agenda items included outcomes of audits, surveys and incidents.

The service also collected data to measure outcomes for patients, and this was used to measure improvement in patients on discharge. This looked at a range of patient activities, such as comprehension, dressing, eating and grooming. The last 3-monthly report showed patients had improved their ability to carry out various tasks and functions across most areas of the service. The provider benchmarked this across all its services.

The quality assurance framework was relatively new and was being developed.

Areas for improvement

The service’s clinical governance meeting minutes showed that responsibility and timelines for actions were not clearly identified.

Action plans we saw were not very detailed or kept up to date. A system should be in place to ensure action plans are properly developed and progressed (see recommendation m).

Staff had limited knowledge of outcomes of governance activities such as audits, incident analysis and surveys. The service should look at ways to communicate findings and actions more effectively to staff (see recommendation n).
No requirements.

**Recommendation m**

- We recommend that the service should implement a system to ensure action plans are properly developed and progressed.

**Recommendation n**

- We recommend that the service should communicate findings of quality assurance activities and outcomes more effectively to staff.
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

#### Requirement

The provider must:

1. update the patient information to make it clear to the complainant that they can refer a complaint to Healthcare Improvement Scotland at any stage of the complaints process (see page 11).

   Timescale – by 1 June 2016

   *Regulation 15 (6)(a)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

#### Recommendations

None

### Quality Statement 0.3

#### Requirements

None

#### Recommendation

We recommend that the service should:

- provide consent training for staff to improve awareness (see page 12).

   *National Care Standards – Independent Hospitals (Standard 26.1 - Mental Health Care)*
### Quality Statement 1.1

**Requirements**

None

**Recommendation**

We recommend that the service should:

- **b** separate patient survey results to ensure feedback is unit specific (see page 13).

  National Care Standards – Independent Hospitals (Standard 9.3 Expressing your views)

---

### Quality Statement 1.6

**Requirements**

None

**Recommendations**

We recommend that the service should:

- **c** ensure all staff receive training in adult support and protection procedures (see page 14).

  National Care Standards – Independent Hospitals (Standard 10.7 Staff)

- **d** review provision of electronic care records and ensure consistency of performance and staff access (see page 14).

  National Care Standards – Independent Hospitals (Standard 14.5 Information held about you)
Quality Statement 2.2

Requirements

None

Recommendations

We recommend that the service should:

**Quality Statement 2.2 (continued)**

e make improvements to the external front entrance of the building to ensure patient safe access and egress (see page 16).

National Care Standards – Independent Hospitals (Standard 15.2 Your Environment)

f upgrade the domestic service room to ensure its safe and fit for purpose. Including the installation of a suitable sink for disposing of dirty water. *Scottish Health Technical Memorandum 64: Sanitary Assemblies* (December 2009) (see page 16).

National Care Standards – Independent Hospitals (Standard 15.2)

g ensure the bath and surrounds are repaired and safe for patient use or decommissioned and removed (see page 16).

National Care Standards – Independent Hospitals (Standard 15.3 Your Environment)

Quality Statement 2.4

Requirement

The provider must:

2 ensure that there are appropriate systems and processes in place for all aspects of care and treatment including infection control. To do this, the provider must:

(a) ensure all staff receive training appropriate to their roles and that this is recorded and monitored
(b) implement a robust auditing and reporting system
(c) ensure that information in regards to infection prevention and control is current reflects best practice and is accessible to all staff. As best practice the service should adopt the Health Protection Scotland’s *National Infection Prevention and Control Manual* (2015) (see page 17).

Timescale – by 1 July 2016

Regulation 3(d)(i)

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

Recommendation

We recommend that the service should:

h review the laundry area and investigate alternative storage options for dirty laundry to

avoid build up (see page 17).
National Care Standards – Independent Hospitals (Standard 15.4 Your Environment)

i implement a system to regularly monitor staff’s hand hygiene practice (see page 17).
National Care Standards – Independent Hospitals (Standard 10.9 - Staff)

### Quality Statement 3.2

**Requirement**

**The provider must:**

3 not employ any person who does not have the qualifications, skills and experience necessary for the work the person is to perform. To do this the provider must ensure that a robust recruitment system is in place which includes uptake of appropriate references and confirmation of qualifications (see page 18).

Timescale – immediately on receipt of report

*Regulation 8(2)(a)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

This was previously identified as a requirement in the 8 April 2015 inspection report for The Huntercombe Services – Murdostoun Brain Injury Rehabilitation Centre

**Recommendations**

We recommend that the service should:

j ensure that records are available to confirm that staff have undertaken induction to the service appropriate to their role (see page 18).

National Care Standards – Independent Hospitals (Standard 10.2 – Staff)

### Quality Statement 3.3

**Requirement**

**The provider must:**

4 ensure that each person employed in the provision of the independent healthcare service receives regular supervision, performance review and appraisals (see page 19).

Timescale – by 1 July 2016

*Regulation 12 (c) (i)(ii)*  
*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

**Recommendations**

We recommend that the service should:

k ensure that robust systems are in place to record and review staff training (see page 19).
<table>
<thead>
<tr>
<th>National Care Standards – Independent Hospitals (Standard 10.2 Staff)</th>
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</thead>
<tbody>
<tr>
<td>I review staff training with staff to ensure training delivered is appropriate to meet the needs of the service (see page 19).</td>
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</table>

National Care Standards – Independent Hospitals (Standard 10.2 Staff)

<table>
<thead>
<tr>
<th>Quality Statement 4.4</th>
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<tbody>
<tr>
<td>Requirements</td>
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<tr>
<td>None</td>
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<table>
<thead>
<tr>
<th>Recommendations</th>
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<tbody>
<tr>
<td>We recommend that the service should:</td>
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</table>

| m | implement a system to ensure action plans are properly developed and progressed (see page 21). |

National Care Standards – Independent Hospitals (Standard 10.9 Staff)

| n | communicate findings of quality assurance activities and outcomes more effectively to staff (see page 22). |

National Care Standards – Independent Hospitals (Standard 10.9 Staff)

This was previously identified as a recommendation in the 8 April 2015 inspection report for The Huntercombe Services – Murdostoun Brain Injury Rehabilitation Centre
Appendix 2 – 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: comments.his@nhs.net
Appendix 3 – 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:

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

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 4 – Inspection process flow chart

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 5 – Terms we use in this report

Terms and explanation

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<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.

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium (SMC) are part of our organisation.