Unannounced Inspection Report: Independent Healthcare

Service: Spire Murrayfield Hospital, Edinburgh
Service Provider: Spire Healthcare Ltd

9–10 August 2022
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 his.contactpublicinvolvement@nhs.scot
## Contents

1. A summary of our inspection .............................................. 4

2. What we found during our inspection ................................. 7

   Appendix 1 – Requirements and recommendations .............. 23
   Appendix 2 – About our inspections ................................. 24
1 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Spire Murrayfield Hospital on Tuesday 9 August 2022. We spoke with a number of staff and patients during the inspection.

The inspection team was made up of three inspectors.

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

What we found and inspection grades awarded

For Spire Murrayfield Hospital, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
</tr>
<tr>
<td><strong>Quality indicator</strong></td>
</tr>
<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
</tr>
</tbody>
</table>
Domain 5 – Delivery of safe, effective, compassionate and person-centred care

5.1 - Safe delivery of care
Safe systems were in place to allow staff to provide safe and effective care. The service had proactive approach to risk management. Staff we spoke with were aware of their responsibilities in delivering safe care and had appropriate training. Equipment we saw was well maintained and clean. ✔️ Good

Domain 9 – Quality improvement-focused leadership

9.4 - Leadership of improvement and change
The service had robust governance and quality assurance systems in place. The service had a clear focus on quality improvement and processes were in place to manage and monitor quality improvement. ✔️ Good

The following additional quality indicators were inspected against during this inspection.

Additional quality indicators inspected (ungraded)

Domain 3 – Impact on staff

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 - The involvement of staff in the work of the organisation</td>
<td>Staff were positive about their work and their colleagues. They felt they had enough training to carry out their job and a system was in place to make sure regular appraisals were carried out.</td>
</tr>
</tbody>
</table>

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

5.2 - Assessment and management of people experiencing care
Care pathways specific to treatment were well completed with evidence of risks and benefits of treatment discussed with patient.

Domain 7 – Workforce management and support

7.1 - Staff recruitment, training and development
Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service.
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.

More information about grading can be found on our website at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Framework can also be found on our website at: https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx

**What action we expect Spire Healthcare Ltd to take after our inspection**

This inspection resulted in one recommendation. See Appendix 1 for the recommendation.

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

We would like to thank all staff at Spire Murrayfield Hospital for their assistance during the inspection.
2 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people’s needs.

Domain 2 – Impact on people experiencing care, carers and families

High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People’s experience of care and the involvement of carers and families

Patients could access information on the service’s website or QR codes for leaflets in the clinical areas. Patients were also provided with information specific to their procedure. Patient feedback was gathered and along with complaints was reviewed and action plans developed if required.

The service’s comprehensive website provided information on the treatments and procedures provided, as well as information about the doctors who carried these out. Patients could also use the website to make enquiries and book their own appointments.

The service had a dedicated team to help patients book their appointments. Contact was made with the patient over the telephone to start with and then their preferred method after that, such as email. Patients were given a choice of consultant as well as the date and time of their consultation. Information about the cost of the consultation and a guide to the cost of any procedure was also given. The information discussed was sent to patients using their preferred method of contact, along with the details of their consultation.

After their consultation and the plan of care was agreed, patients received more specific information about their planned procedure and coming into hospital. We saw patient information leaflets with information about the procedure and any risks associated with it. At this time, patients also received information including advice about their planned type of anaesthetic, COVID-19 and how to stay well before surgery. We were told that patient information leaflets were available in different formats or languages if required. The service could access translation services and we saw posters in the hospital highlighting this. Patient leaflets were available through a QR code that could be downloaded electronically.
Before their procedures, patients completed an electronic medical questionnaire that a nurse reviewed to decide whether a pre-assessment appointment was required. The pre-assessment staff supported patients who were unable to complete this form electronically. Patients who required a pre-assessment appointment had this carried out over the telephone or face-to-face. They could also be asked to attend a clinic appointment so that blood tests and recordings could be taken, such as blood pressure and heart tracings. We were told that patients discussed their planned procedure with the pre-assessment staff at this time.

After their pre-assessment appointment, patients were sent information that included:

- the date and time of their procedure
- any fasting instructions
- post-procedure advice, and
- any special instructions for taking or not taking their existing medication.

Staff in the pre-assessment team told us that they attended a weekly meeting with staff involved in the patient’s care. At these meetings, any special requirements or enhanced care that the patient may require was identified and the necessary support or equipment could be put in place.

We were told that the service hosted online patient events that were usually consultant-led, where patients could submit questions or ask them directly about a condition or procedures. These events were free and could be booked through the service’s website.

The service had a dedicated member of staff that managed complaints and acted as a single point of contact. Staff had received training in complaints handling. A clear process was in place for the management of complaints. Information about how to make a complaint was visible at reception. We were told that someone making a complaint received an acknowledgement letter with timescales for a response and how they could escalate their complaint, including to Healthcare Improvement Scotland. The person making the complaint would also be offered a face-to-face meeting with a member of the senior management team. An electronic platform was used to monitor the status of complaints and progress with action plans developed if the complaint was upheld. We were told that a weekly meeting with the hospital director discussed this progress and any emerging themes. We saw that complaints were discussed at a meeting held every 4 weeks with the heads of departments and team leaders. The owner of the complaint was expected to make sure that the
actions were completed and any learning shared with their team and the whole service. We heard complaints being discussed at the daily staff huddle.

The majority of patient feedback the service gathered was from an electronic link given to patients after discharge. We saw that some areas were using QR codes to gathered feedback and we were told that this was planned to be introduced to other areas in the hospital. Monthly reports summarising feedback were sent to heads of department and team leaders and were to be shared with staff. Reports published every 3 months displayed patient feedback in pictures and covered a variety of aspects of the patients’ stay, such as:

- care received
- the hospital facilities, and
- the information given.

The results were displayed in specific areas in the hospital. Results for June 2022 showed that, of the patients who responded:

- 94% thought they had received excellent care from nursing staff
- 97% responded positively to their experience of the treatment received, and
- 86% had felt fully informed.

In several areas, we saw feedback from patients displayed with actions of how staff had acted on it.

The ward area had introduced a patient experience co-ordinator whose role was to regularly speak with patients each day, check on their welfare and address any concerns they had in real time. They could speak directly with the complaints team if required. Staff spoke positively of this initiative.

The service had a duty of candour policy in place, where healthcare organisations have a professional responsibility to be honest with patients when things go wrong.

We were aware that patient forums which had previously been in place had been suspended in response to the COVID-19 pandemic. We were told that these would be restarted to gather real-time patient views and feedback on how the service could develop.

- No requirements.
- No recommendations.
Domain 3 – Impact on staff
High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

Our findings

Quality indicator 3.1 - The involvement of staff in the work of the organisation

Staff were positive about their work and their colleagues. They felt they had enough training to carry out their job and a system was in place to make sure regular appraisals were carried out.

The most recent colleague survey was completed in October 2021. Responses were generally positive about how interesting and fulfilling the jobs were, making good use of skills and staff said they felt trusted to do their job. Each department had developed an action plan to address issues identified in the survey. For example, inviting a member of the senior leadership team to the department’s staff meeting and providing monthly education for healthcare assistants.

We saw completed staff appraisals on the online appraisal system. Staff we spoke with stated that these helped with their career goals and helped them to feel valued. Staff said they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training. This included medical staff not employed directly by the provider but given permission to work in the service with practicing privileges.

We saw a staff induction process in place for new staff. All new staff we spoke with had a period of induction and had completed an induction programme. We saw clear job descriptions for each role detailed roles and responsibilities.

Clinical staff had link nurse or ‘champion’ roles for different areas, such as cleanliness or pain management. Clinical staff were also encouraged to take responsibility for promoting best practice and improvements in these areas.
We sent out an anonymous survey which asked five ‘yes or no’ questions, along with one on staff views for what the service does really well and what could be improved. The results showed the following:

- The majority of staff said that the highest level of the organisation had positive leadership.
- The majority of staff said that the service had a positive culture.
- Not all staff felt that they could influence how things were done in this service.
- The majority of staff said their line manager took their concerns seriously.
- The majority of staff said that they would recommend this organisation as a good place to work.

Staff comments received from our survey were mixed. However, in general staff we spoke with were positive about the hospital. Comments included:

- ‘Good place to work, nice people and good variety of work.’
- ‘All staff work well together including medical staff and all are very welcoming and supportive.’

Staff received newsletters, emails and could attend meetings and forums to keep up to date with changes in the hospital. Staff told us they received information and training on new initiatives and when legislation changed, such as for data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

The service had a staff recognition initiative called ‘inspiring people’, where staff who were nominated received a certificate of recognition and a voucher to spend in a number of retailers. We were told that the initiative was actively promoted by the heads of departments and team leaders. The service had introduced other staff initiatives, including ‘freedom to speak’ guardians. Staff could speak with these guardians in confidence if they had any concerns about their work. Staff knew of this initiative and how they could raise any concerns. Mental health first aiders were also there to support staff and we saw posters promoting these initiatives.

The service had recently introduced an A4 poster called ‘Feedback Friday’, which gave an overview of incidents reported and learnings from them. The hospital’s clinical governance team shared this with all colleagues.

- No requirements.
No recommendations.
Service delivery

This section is where we report on how safe the service is.

**Domain 5 – Delivery of safe, effective, compassionate and person-centred care**

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

**Our findings**

**Quality indicator 5.1 - Safe delivery of care**

Safe systems were in place to allow staff to provide safe and effective care. The service had proactive approach to risk management. Staff we spoke with were aware of their responsibilities in delivering safe care and had appropriate training. Equipment we saw was well maintained and clean.

Appropriate governance systems and policies were in place to make sure the environment was safe, met people’s needs and supported them. This included a proactive approach to the improvement of safety, reducing harm and improving reliability of care through a culture of openness, transparency and continuous learning.

Appropriate risk management systems in place covered the care, support and treatment delivered in the service. Staff were aware of their responsibilities and suitable training was in place.

Staff we spoke with had completed training essential to their role and staff files had training lists of completed mandatory training, which were signed and dated. Dates for refresher training were included. We saw evidence of future training opportunities for staff on staff boards. Many staff had enhanced roles in addition to their substantive post and reported they had allocated time to focus on these. Examples included:

- education and training champion
- mental health champion, and
- safeguarding champion.

Newly appointed staff reported that they felt ‘valued’ and ‘wanted’ and said they felt that their previous skills both professionally and life learned were
acknowledged and valued. Training for staff new in post was encouraged, with staff saying that their line manager reminded them if they still had training to complete.

Systems were in place to help prevent and control infection in the hospital. For example, a green sticker was dated and applied to equipment after it had been cleaned so that staff knew it was ready for use. Overall, we saw that staff demonstrated good compliance with infection prevention and control policies and procedures. Clinical areas were uncluttered and clean, equipment was overall clean and we saw labels demonstrating this on equipment.

Cleaning schedules were in place in all areas, including individual consulting rooms and we saw that these were completed. Clinical waste was managed effectively in all areas.

Staff we spoke with told us that mandatory infection prevention and control training was completed every year. Heads of departments could access an online system that tracked staff compliance with education in their department. Staff told us that senior managers supported them in continuing education and development to improve knowledge and skills.

Patients we spoke with told us that they thought the hospital was clean and reported that it was ‘cleaned frequently during the day’. Patients also told us they felt safe and well cared for.

The service used an electronic platform to carry out and monitor audits. Each department was responsible for carrying out these audits, which included hand hygiene, hospital cleanliness and record-keeping. The pharmacy department carried out regular audits in the ward areas, including those for:

- antibiotics post-discharge
- drug chart audit
- patients’ own controlled drugs, and
- storage of medicines.

The pharmacy department also regularly audited controlled drug registers in departments, which stored controlled drugs.

The senior management team had oversight of the compliance and results. Audit results were visible to all staff through provider’s clinical audit system in the form of dashboards and were discussed at governance meetings.
The service had an electronic risk register and each area had oversight of its top risks, while the senior management team had oversight of all the service’s risks. In our discussion with members of the senior management team, it was clear the team was aware of the current risks to the service. Staff we spoke with were aware of the top risks in their department and we saw these displayed in staff areas.

We attended two safety huddles, one in theatres and the other was a virtual hospital safety huddle. Staff groups attending the theatre safety huddle included:

- anaesthetic
- estates
- medical
- nursing, and
- senior management.

Topics discussed at this huddle included the scheduled cases, staffing, equipment and whether it was safe to proceed in each theatre for the day. A representative from each department attended the virtual hospital safety huddle, including those from pharmacy, clinical governance and senior management along with representatives from the provider’s other hospital in Edinburgh. This was to make sure messages were aligned and to provide mutual support. At the virtual huddle, topics discussed included:

- equipment
- incidents
- maintenance
- patient flow
- risks
- safety issues
- staffing, and
- whether each department in both sites was safe to proceed.

We saw evidence of good standards of medicines management, including completed records of stock checks. Audits were discussed and we saw records of these. The medicines fridge was checked regularly, including its contents and daily temperatures. Staff knew the process for reporting faults.
We saw emergency equipment was checked once in every 24 hours and the kits were kept in a secure area that staff could access. Staff were able to describe the process they would follow if extra emergency equipment was required in a situation. The resuscitation officer told us that the hospital was reviewing the contents of the emergency trolley. As a result of this, changes were planned to some of the items held in the trolley. The service had recently invested in new resuscitation training equipment, which required all relevant staff to complete refresher training every 90 days using the simulator programme. This helped make sure key skills were up to date.

To help assess the safety culture in the service, we followed a day case patient’s journey from the ward through theatre, recovery room and then discharge home. We saw that staff followed World Health Organization guidelines, such as taking a ‘surgical pause’ before starting surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments in line with guidelines, including those for tracking and tracing instruments used.

A nurse or other suitable member of staff accompanied patients to and from the theatre department. Staff took time to talk and listen to the patient at each point in the journey, with various staff introducing themselves and explaining what was happening. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. Patients’ privacy and dignity was maintained at all times. We saw effective multidisciplinary working with informative staff handovers and communication at all stages in the patient journey.

**What needs to improve**

While the service was clean, we did not see any evidence that clinical hand wash basins were being cleaned with 1000ppm chlorine solution in line with national guidance (recommendation a).

- No requirements.

**Recommendation a**

- The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks in line with national guidance.
Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Care pathways specific to treatment were well completed with evidence of risks and benefits of treatment discussed with patient.

Before admission, patients had a consultation and completed a medical questionnaire, which determined whether a telephone consultation with the pre-assessment nurse or a face-to-face assessment was needed before admission. Every patient also had to complete an assessment form and mail it back to the service. Pre-assessment information was noted in all patient care records we inspected.

The five patient care records we looked at were detailed with patient risk assessments completed, such as those for venous thromboembolism (blood clots), pressure area care and malnutrition. We saw all consent-to-treatment forms had been completed, signed and dated by the consultant and the patient in the same day.

Patients having surgery had a World Health Organization surgical safety checklist completed in their care records. We saw that patients had appropriate care immediately after their treatments in the recovery area and this was documented in the patient care records. Evidence of the planned follow-up was found in the operation notes the consultant had written in the patient care record.

Medicine prescription charts and medicines administration records were well completed.

We saw that patient care records were audited as part of the audit programme and had been completed.

Patient care records were securely stored to maintain confidentiality, in line with the records management policy.

- No requirements.
- No recommendations.
Domain 7 – Workforce management and support

High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Quality indicator 7.1 - Staff recruitment, training and development

Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service.

Like other services, staffing could be challenging. However, the service was actively trying to recruit to vacancies and in some areas, trying to ‘over-recruit’ as a contingency and to provide some flexibility. We were told that agency and bank staff were used when available to cover staffing gaps.

We saw that the service had a recruitment policy in place, as well as a practicing privileges policy. The service carried out the appropriate pre-employment checks and had a written agreement with staff working under practicing privileges.

The six electronic staff files we reviewed were well organised. We saw evidence of effective recruitment in all staff files and any gaps in the staff files were highlighted at the time of our inspection. Recruitment checks included:

- checking the protecting vulnerable groups (PVG) status of the applicant
- checking professional registration and qualifications where appropriate, and
- obtaining references.

Staff files had a checklist to help make sure that appropriate recruitment checks had been carried out.

All employed staff had completed an induction, which included:

- an introduction to key members of staff in the service
- mandatory and statutory training, and
- role-specific training.
The staff member kept the document and updated it with their progress. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff.

Mandatory and optional staff training was monitored using an online platform. All staff were allocated a number of mandatory eLearning modules initially and then allocated role specific modules some of which may have been mandatory for their role. Mandatory training covered safeguarding of people and duty of candour (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Heads of departments, team leaders and the senior management team could monitor compliance with mandatory training. We were told that the service was working on how to make the reporting of training data more accurate and meaningful. We saw that the majority of staff had fully completed their mandatory training for the year ending March 2022.

We saw that appraisals had been carried out for all staff for the previous year, with new objectives set for 2022. Appraisals for 2022 had started.

Staff we spoke with were clear about their roles and the reporting structures in the service.

- No requirements.
- No recommendations.
**Vision and leadership**

This section is where we report on how well the service is led.

**Domain 9 – Quality improvement-focused leadership**

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

**Our findings**

**Quality indicator 9.4 - Leadership of improvement and change**

The service had robust governance and quality assurance systems in place. The service had a clear focus on quality improvement and processes were in place to manage and monitor quality improvement.

The service had clear leadership and governance structures. The service had a number of meetings, which included a weekly meeting between the senior management team, heads of department and team leaders. This meeting had a rotating agenda which included complaints, governance and health and safety.

Infection control, health and safety and medical advisory committee meetings were held every 3 months. The service told us it also had regular governance meetings where any concerns were escalated to the provider. Members of the senior management team that we spoke with told us that they felt supported by corporate teams from the provider, such as education and critical care.

Feedback to staff from these meetings was expected to be provided by the heads of departments and team leaders. A monthly newsletter sent to all staff was also used to disseminate key themes from these meetings.

We were told that a monthly staff forum with members of the senior management team was held virtually. Staff could submit questions before the forum or could ask them at the time. During the safety huddle, we heard those present being asked to encourage staff to attend these forums.
The service had developed six strategic priorities in line with those of the provider. The priorities were:

- behaviours to deliver safe and efficient patient care
- patient first
- improving competence across teams
- ensuring a safe and efficient system of working
- improving speed of access, and
- increasing efficiency in internal processes.

The senior management team met every 3 months to review progress with these priorities.

We saw a quality assurance system was in place in the hospital. A corporate quality improvement strategy, a quality improvement programme and quality improvement project lead were in place. The provider had a focus on quality improvement and had a methodology, standard approach and resources available to support quality improvement. The staff intranet had a dedicated quality improvement site in it. Staff could complete quality improvement modules, from foundation (level 1) through to ‘QI Coach’ (level 5).

All staff were expected to be involved in quality improvement and training to different levels of quality improvement competence was available. Individual teams in the service were encouraged to develop their own quality improvement projects in line with the strategic priorities of the service.

We were told about quality improvement projects in the service, including:

- discharge planning
- falls
- improving results from ward-based audits
- introduction of tablet computers to increase patient feedback after certain procedures, and
- nursing documentation.

The projects were regularly reviewed and improved where necessary to address any issues or challenges identified so that the objective could be reasonably achieved in the timeframes identified.
A comprehensive quality improvement plan was in place to monitor and review the progress with the service’s quality improvement work.

- 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 National Health Services (Scotland) Act 1978, 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.

### Domain 5 – Delivery of safe, effective, compassionate and person-centred care

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

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service should comply with national guidance to make sure that the appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical hand wash sinks (see page 15).</td>
</tr>
</tbody>
</table>

Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

**Before inspections**

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

**During inspections**

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

**After inspections**

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require independent healthcare 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.

More information about our approach can be found on our website: [www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach.aspx)
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

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

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot