Unannounced Inspection Report: Independent Healthcare

Service: Priory Ayr Clinic, Ayr
Service Provider: The Priory Group Limited

3-4 November 2021
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
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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 17-18 September 2018

Recommendation
The service should upgrade its clinical hand wash basins as part of future planned refurbishment.

Action taken
Since the last inspection in September 2018, the service had replaced the taps on clinical hand wash basins. However, the clinical hand wash basins were still not compliant with current standards. A requirement has been made in Quality indicator 5.1 (see requirement 1).

Recommendation
The service should ensure care plans include input from patients in respect of their personal goals and wishes. Patients should sign care plans pertaining to their care and where this is not possible it should be clearly evidenced within the care record.

Action taken
We saw evidence of patient involvement in care plans, and it was clear from this that patients had the opportunity to identify their own personal goals and wishes. We saw that patients had signed their care plans, and for those patients who refused, or where it was not possible, the reasons were recorded in the patient care record. Patients were given a copy of their care plan if they wished.

Recommendation
The service should review its staff office accommodation and develop a plan to improve space and ventilation.

Action taken
We were told that approval had been granted for the installation of air conditioning in the staff office accommodation. However, this had not yet been installed. This recommendation is reported in Quality indicator 5.1 (see recommendation a).
**Recommendation**
*The service should review all documentation against the requirements of Scottish legislation.*

**Action taken**
Since the last inspection in September 2018, the service had developed a small number of new policies in line with Scottish legislation, for example the adult support and protection policy. However, a wide range of policies and documents, produced by the provider, still referred to English legislation and regulation. A requirement has been made in Quality indicator 9.4 (see requirement 2).

**Recommendation**
*The service should ensure staff understand the requirements of the duty of candour.*

**Action taken**
The majority of staff we spoke with were able to demonstrate a good understanding of the requirements of duty of candour. This ensures the service responds appropriately to any unintended or unexpected incidents that occur in the service. We saw evidence that 85% of staff had completed duty of candour training.
2 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 three 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 the Priory Ayr Clinic (formerly PiC Ayr Clinic) on Wednesday 3 and Thursday 4 November 2021. We spoke with a number of staff and patients during the inspection and visited the three service sites including the Priory Ayr Clinic, and its two step-down community houses: The Gatehouse and Lochlea House.

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 the Priory Ayr Clinic, the following grades have been applied to three key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<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>
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</table>
## Key quality indicators inspected (continued)

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

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 - Safe delivery of care</td>
<td>A number of policies and procedures were in place to ensure safe delivery of care. A risk assessment tool and various initiatives to help reduce incidents of violence and aggression had been implemented. Clinical hand wash basins must be upgraded and ventilation in staff offices reviewed.</td>
<td>✔️ Good</td>
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### Domain 9 – Quality improvement-focused leadership

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
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<tr>
<td>9.4 - Leadership of improvement and change</td>
<td>A clear governance structure was in place. Managers were visible, and staff found them approachable and supportive. The service acted on lessons learned from incidents and was responsive to making changes to practice in line with its quality improvement plan. All policies must be in line with Scottish legislation.</td>
<td>✔️ Good</td>
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The following additional quality indicators were inspected against during this inspection.

## Additional quality indicators inspected (ungraded)

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

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tbody>
<tr>
<td>5.2 - Assessment and management of people experiencing care</td>
<td>All patients were assessed and reviewed regularly by the multidisciplinary team. Clear systems were in place for staff to communicate any changes to patients’ needs or presentation.</td>
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</table>

### Domain 7 – Workforce management and support

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<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tr>
<td>7.1 - Staff recruitment, training and development</td>
<td>Good systems and processes were in place to ensure staff continued to be recruited safely. Staff files were comprehensively completed. Education, training and development opportunities were available for staff. Annual appraisals were carried out.</td>
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</tbody>
</table>
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

**What action we expect The Priory Group Limited to take after our inspection**

This inspection resulted in two requirements and two recommendations. Requirements are linked to compliance with the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

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

The Priory Group Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at the Priory Ayr Clinic for their assistance during the inspection.
3 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 and carers were involved in decision making and care planning. Patients were given the opportunity to provide feedback to help inform how the service continued to develop and improve. Although patients spoke positively about the standard of care, they also told us how they felt their care could be impacted at times due to staffing issues.

We saw evidence of patient involvement in developing individualised care plans. From our review of patient care records, we saw that care plans were developed in collaboration with patients and the personal goals identified were driven by patients’ individual needs. We saw that some patients had signed and accepted a copy of their care plan. For those who did not, the reason was recorded in the patient care records.

We saw that patients’ family, carer or named person had the opportunity to be involved in decision making and the care planning process where patients agreed. This included attending or contributing to the weekly individual care reviews.

We saw that a range of meaningful activities including creative, self-care and exercise groups took place, and a number of therapeutic interventions including dialectical behaviour therapy were available for patients to access and engage with.

We saw that patients had the opportunity to give feedback about their experience of care. We saw evidence of patient forum meetings where patients could express their views about issues such as the environment, activities and their care. We also saw evidence of patients receiving updates from staff about what actions were being taken to address any concerns or suggestions made.
during these meetings. The service also gathered feedback through suggestion boxes and a survey for discharged patients. We were told that all feedback was reviewed by management and discussed in team meetings.

We saw positive patient feedback about the quality of care. Comments included:

- ‘I think the ward is run well and all patients are supported.’
- ‘There is a good range of activities during the day and evening.’
- ‘I was involved in developing my care plan with my personal goals.’

We saw an up-to-date complaints policy and clear processes for patients to report concerns or complaints. We saw that all concerns and complaints were taken seriously and responded to suitably. Clear information on how to complain was available in patient areas.

**What needs to improve**

All carers were routinely sent a feedback questionnaire to return by post or complete electronically. However, the service had only received a small number of returns. We were told the service was planning to look at ways to develop carer engagement. It was hoped this would help to improve feedback response rates to help identify future areas for improvement. We will follow this up at a future inspection.

There was consistent feedback from patients and staff that patient care was affected when staffing numbers were low. We were told about patients’ access to leave being restricted when there was not sufficient staff numbers. Patients’ access to the garden could also only be facilitated when staffing permitted. Both staff and patients told us that patients were sometimes only able to access the garden twice a week due to staffing issues. The service manager was aware of the staffing issues and was currently working on staff recruitment and improving retention. We will follow this up at a future inspection.

- 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

A number of policies and procedures were in place to ensure safe delivery of care. A risk assessment tool and various initiatives to help reduce incidents of violence and aggression had been implemented. Clinical hand wash basins must be upgraded and ventilation in staff offices reviewed.

Policies and processes were in place and readily available to all staff on the organisational intranet. These included infection prevention and control, and adult support and protection policies.

We saw that the housekeeping staff had good processes in place to ensure the environment remained clean. This included cleaning schedules and a wide range of cleaning products available. The environment was clean and mostly well maintained.

During the COVID-19 pandemic, enhanced procedures were put in place to keep staff and patients safe. This included restricted access to the service, the use of personal protective equipment, such as disposable aprons and gloves, and patient isolation when required. Various aspects of personal protective equipment continued to be used by staff and were readily available for visitors to the service.

The maintenance team had a thorough programme in place to ensure that an ongoing assessment and review of the environment and patient equipment took place. For example, fire risk assessments and fire evacuation protocols were kept up to date and were readily available for ward staff to access quickly. This included personal emergency evacuation plans for individual patients who may have difficulty when evacuating in a fire or who may decline to do so.
We saw examples of initiatives being introduced for managing challenging behaviour and to promote the safety and wellbeing of patients. This included an evidence-based model (‘Safewards’) designed to encourage staff and patients on the ward to work together to reduce conflict and provide a peaceful, safe environment. Safety pods, specially designed beanbags which increased patient and staff safety during physical interventions, were located in each facility. We saw evidence that implementing these measures had led to a reduction in violence and aggression incidents. Staff told us these initiatives had enabled them to improve safety and quality of care.

A risk assessment tool was also being used to assist in the prediction of violence and aggression. This helped staff to know when to intervene before an incident occurred. Patient ‘scores’ were reviewed every day to assess the potential risk of violence and enable focused preventative intervention including additional staff resourcing.

An up-to-date prevention and management of disturbed/violent behaviour policy was available. This focused on the prevention and reduction of incidents resulting in physical intervention for distressed patients. We saw that all staff had access to prevention and management of violence and aggression training and the service had identified staff to take a lead with future training.

Personal alarms and radios were available for staff to use in an emergency. Staff call points were located throughout the service and in patient bedrooms so that patients could call for assistance if required.

Up-to-date ligature point risk assessments identified potential ligature points and detailed what action had been taken to remove or manage these.

Reliable systems were in place to manage risk and a comprehensive register of practice-associated risks and their impact was maintained. This was regularly reviewed through the clinical governance structures. Risk assessments were in place to protect patients, visitors and staff covering the environment, safety and security, and infection prevention and control. Each risk assessment had a likelihood of occurrence attached. We saw that each risk was reviewed on a regular basis and that all necessary action plans were in place.

An audit programme had been implemented with regular audits carried out. These included medicine management, ligature awareness, environmental, and infection prevention and control. We saw examples of completed audits with areas for improvement identified with planned actions and timescales for completion. Outcomes from audits were discussed at staff, management and clinical governance board meetings.
A duty of candour policy was in place and the service had produced an annual duty of candour report detailing that no incidents had triggered the need to act.

A medicines management policy was in place and we saw evidence of safe procurement, storage, administration and disposal of medication. We saw processes in place for auditing medication stock and the completion of administration charts.

We saw a detailed policy, suitable medical equipment and medication for responding to emergencies.

**What needs to improve**

Although some upgrades had taken place to sanitary fittings since the last inspection in September 2018, we found that clinical hand wash basins were still not compliant with current standards (requirement 1).

There was lack of ventilation in staff offices which were also small in space. We were told that approval had been granted to install air conditioning in the staff office accommodation. However, this had not yet been installed (recommendation a).

**Requirement 1 – Timescale: immediate**

■ The provider must upgrade its clinical hand wash basins as part of future planned refurbishment and develop a risk assessment for the current sinks.

**Recommendation a**

■ The service should review its staff office accommodation and develop a plan to improve space and ventilation.

**Our findings**

**Quality indicator 5.2 - Assessment and management of people experiencing care**

All patients were assessed and reviewed regularly by the multidisciplinary team. Clear systems were in place for staff to communicate any changes to patients’ needs or presentation.

From the patient care records reviewed, we saw that all patients received a thorough assessment for suitability of admission, and had ongoing assessment and review of their treatment throughout their admission. All patients had an individual care review meeting every week with the psychiatrist and a mental
health nurse, and every month with a wider group of professionals from the multidisciplinary team.

All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, and appropriate legal consent and treatment documentation was in place. We saw a number of patients had completed written advance statements detailing their preferences, wishes, beliefs and values about their future care.

Using an established care pathway framework, patients’ holistic needs were regularly reviewed with input from suitable professionals. This included patients being allocated a community mental health nurse who had input during their admission, but also continued to support the patient in the community. We saw evidence of patients who had progressed through the care pathway to the provider’s step-down community rehabilitation services.

Patients were aware of their right to access independent advocacy services and we saw information posters displayed throughout the service.

We saw that all patient care records were stored electronically. Staff had individual password-protected accounts for accessing and documenting patient information.

Patient care record audits were carried out every week. A dashboard system highlighted when patients’ risk assessments and care plans were due for review. We saw evidence of audit findings being fed back to staff in staff meetings to action or address themes.

We saw that all patients had personalised risk assessments. These were updated regularly or when there were changes to an individual’s risk levels. Patients’ risks and progress was communicated among staff during regular verbal handovers between each shift.

The frequency and level of patient observations was decided by the multidisciplinary team based on a patient’s presentation and needs. We saw evidence of completed observation checks and therapeutic activities that had taken place during this intervention as part of a patient’s care plan.

The majority of patients spoke positively about their care and felt involved in planning their treatment.
What needs to improve

We saw that patients on high doses of antipsychotic medication received additional physical health monitoring. Some patients had their physical observations recorded on the high dose antipsychotic therapy monitoring chart. However, this was not being completed consistently across ward areas. For example, on some wards we found blank monitoring charts as the information was being recorded on the electronic patient care system. To ensure patient safety, all monitoring charts should be completed in full and be accessible consistently across the service (recommendation b).

Patient care records showed whether patients had accepted a copy of their care plan, and the majority of patients told us they had received a copy. However, a small number of patients told us they had not been offered a copy. Staff told us that patients will continue to be regularly offered a copy of their care plan and this will be recorded. We will follow this up at a future inspection.

- No requirements.

Recommendation b

- The service should ensure physical health monitoring charts are completed consistently across wards.

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.

Our findings

Quality indicator 7.1 - Staff recruitment, training and development

Good systems and processes were in place to ensure staff continued to be recruited safely. Staff files were comprehensively completed. Education, training and development opportunities were available for staff. Annual appraisals were carried out.

We saw that the service had followed its safer recruitment and selection policy from the five staff files we reviewed. This included staff granted practicing privileges (staff not employed by the provider but given permission to work in the service). Pre-employment checks such as proof of identity, qualifications, occupational health screening and references had been carried out. Staff files contained job descriptions and signed contracts of employment. We saw processes in place to ensure staff had up-to-date Protecting Vulnerable Groups...
(PVG) background checks and maintained their registration and insurance. Staff had clear roles, responsibilities and accountabilities.

New staff completed a 6-month role-specific induction and probation period under the supervision of their line manager. This included an online training and education package, hands-on training, and a period of shadowing and supervision. Staff were given an induction workbook as part of their induction programme. This set out the induction and probation process, relevant policies, checklists and questions to be completed by the staff member. Induction meetings to monitor a new staff member’s performance, competence and compliance with the provider’s standards and procedures were held at regular intervals during the induction period. As the workbook was completed, the line manager assessed the knowledge of the new staff member and signed off each part when competence was demonstrated.

We spoke with the training co-ordinator who organises mandatory and refresher training programmes for staff and maintains an electronic training matrix. This records course completion rates and individual staff compliance details. Staff were expected to complete mandatory training on a range of topics relevant to their roles. This included basic life support, public protection (safeguarding), infection prevention and control, and fire safety.

The training co-ordinator monitored completion of training to make sure that all staff were up to date, and had the necessary knowledge and skills to do their role. Training compliance was regularly monitored to ensure compliance was maintained. At the time of the inspection, this was at 83%. Clear actions were in place for addressing any outstanding training requirements. We were told that a training needs analysis would be carried out to identify any training needs in response to changes in the patient group. This would help staff to continue to support care planning for patients.

Staff spoke favourably about the opportunities available to attend additional training and events to support their continuous professional and personal development. We noted that staff were provided with opportunities to carry out continued education. This included leadership training, postgraduate courses in forensic health, advanced nurse practitioner training and staff training to become trainers in psychotherapy treatments. Staff told us the process of applying for further training was a positive experience and was encouraged by the service.

A staff performance and development review policy was in place. As part of this process, staff told us they had the opportunity to discuss any concerns, progress in their role and career developments. Learning and development needs were also identified which helped feed into the planning of the training matrix. We
saw evidence that staff, including those granted practicing privileges, had received annual appraisals. This included a 6-monthly review meeting which provided staff with an opportunity to reflect on their personal development and ensure they were on track to achieve their learning goals.

A supervision structure (a formal process of support and learning) was in place and staff confirmed they had regular one-to-one monthly supervision sessions. Staff also spoke positively about group supervision and reflective practice sessions.

We saw evidence of support available for all staff including an external employee counselling service, local wellbeing information on each ward and regular opportunities to debrief about patient safety or concerns. Staff had monthly face-to-face meetings with their line managers to allow them to debrief and talk through issues.

**What needs to improve**
The service was in the process of recruiting and training new staff to ensure safe staffing levels. In the meantime, the service had temporarily put new admissions on hold as it focused on staff recruitment and improving retention. We will follow this up at a future inspection.

Staff told us that, due to COVID-19 restrictions, management of violence and aggression training class numbers had been reduced. This had an impact on the staff numbers who could attend. We noted that a purpose-built training room at Lochlea House was nearing completion. This would help support the training of staff in larger numbers and address any outstanding training requirements. We will follow this up at a future inspection.

- 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**

A clear governance structure was in place. Managers were visible, and staff found them approachable and supportive. The service acted on lessons learned from incidents and was responsive to making changes to practice in line with its quality improvement plan. All policies must be in line with Scottish legislation.

The service had a clear governance process in place. The senior management team comprised three hospital directors, the head of psychology and the support services manager. During the pandemic, the team met every day to ensure a safe service. At the time of our inspection, the senior management team was now meeting every month. However, they also often meet on a more regular, informal, basis.

The regional director and service manager attended ‘divisional cascade’ meetings every week with directors of the provider organisation. Subjects discussed included safety alerts, adverse events and any necessary actions to be taken. This information was then passed to the appropriate heads of department in the service and passed on to all staff. We saw minutes of ward meetings carried out by the ward manager where this information was discussed.

A clinical governance meeting took place every month. A more structured standard format for the agenda had recently been introduced by the provider. Subjects discussed included patient and carer experience, adverse events and clinical risk management, and continuous quality improvement. We saw evidence of the new agenda format and minutes of recent meetings. This included an action plan and named staff delegated to carry out any required actions. Staff told us the new meeting format was more useful.
An electronic system was in place for recording, reviewing and monitoring incidents. Staff told us there was an open incident reporting culture, and they knew how to report incidents. We reviewed the records for a recent physical aggression incident. We saw evidence that this had been investigated carefully and thoroughly. Regular incident reports were produced so that the occurrence of incidents could be reviewed and analysed. Arrangements were in place to disseminate information and lessons learned from incidents to staff and through the senior management governance systems. The service notified Healthcare Improvement Scotland of specific events or circumstances, as required. If the incident was significant, then this would be presented at the divisional cascade meeting along with the lessons learned.

Staff told us that the senior leadership team and ward managers were approachable and frequently visible in the wards. Staff also told us they enjoyed working for the service and felt valued, respected and fully supported by their colleagues and managers. They said they had confidence to speak with management if they needed to raise issues or concerns.

The service’s quality improvement plan reviewed performance looking at key quality of care processes and outcomes. This helped to ensure that any necessary improvements were made and lessons learned discussed. This included a review of the line management structure, and systems in place for staff supervision and reflective practice. We were told that, in response to patient feedback, a newsletter had been introduced as a way of sharing information with patients.

Through the staff engagement strategy, the service was monitoring the impact the pandemic had on the workforce. This strategy looked at how to improve staff retention, morale and a feeling of belonging.

We saw evidence of the senior team attending a number of benchmarking forums of the forensic network community throughout the United Kingdom, as well as the Independent Healthcare Providers Network Scotland. The outcome of these forums was fed back to the clinical governance meeting every month and ensured ongoing learning and development of the service.

Senior staff had also carried out a peer review with similar services. They told us this was a positive experience and allowed the service to review job roles, processes and procedures with other similar services.
What needs to improve

Whilst a wide range of policies were easily available to staff electronically, a significant number of policies and documents referred to English legislation and the English regulatory body. All policies implemented in the service must be in line with Scottish legislation and reference Healthcare Improvement Scotland as the regulatory body (requirement 2).

We were told the annual staff survey had recently been completed. However, the results were not yet available. The service manager highlighted that the main issue in recent years had been staff engagement and retention. This was being currently addressed with the provider. We will follow this up at a future inspection.

Requirement 2 – Timescale: by 4 April 2022

- The provider must ensure that all policies and documentation used in the service refers to Scottish legislation and Healthcare Improvement Scotland as the regulatory body.

- 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

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<tr>
<th>Requirement</th>
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Timescale – immediate

*Regulation 3(d)(i)(iii)*  
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

This was previously identified as a recommendation in the September 2018 inspection report for PiC Ayr Clinic.

<table>
<thead>
<tr>
<th>Recommendations</th>
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<td>a</td>
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Health and Social Care Standards: My support, my life. I experience a high quality environment if the organisation provides the premises. Statement 5.22

This was previously identified as a recommendation in the September 2018 inspection report for PiC Ayr Clinic.
## Domain 5 – Delivery of safe, effective, compassionate and person-centred care (continued)

**Recommendations**

<table>
<thead>
<tr>
<th>b</th>
<th>The service should ensure physical health monitoring charts are completed consistently across wards (see page 15).</th>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.27

## Domain 9 – Quality improvement-focused leadership

**Requirement**

<table>
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<tr>
<th>2</th>
<th>The provider must ensure that all policies and documentation used in the service refers to Scottish legislation and Healthcare Improvement Scotland as the regulatory body (see page 20).</th>
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Timescale – by 4 April 2022

*Regulation 2*

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

This was previously identified as a recommendation in the September 2018 inspection report for PiC Ayr Clinic.

**Recommendations**

None
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